MEDICARE REIMBURSEMENT TO COMPETITIVE MEDICAL PLANS

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-SEVENTH CONGRESS

FIRST SESSION

WASHINGTON, D.C.

JULY 29, 1981

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE
84-278 O WASHINGTON: 1981

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402

S141-28

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CONTENTS

	Page
Opening statement by Senator John Heinz, chairman	1
Statement by Senator William S. Cohen	4

CHRONOLOGICAL LIST OF WITNESSES

Kay, George H., beneficiary, Fallon Community Health Plan, Worcester, Mass	5
Voita, George, beneficiary, SHARE Health Plan, St. Paul, Minn., accompanied by Ruth Voita	6
Hacking, James M., Washington, D.C., assistant legislative counsel, National Retired Teachers Association/American Association of Retired Persons	11
Clayman, Jacob, Washington, D.C., president, National Council of Senior Citizens	28
Reynolds, Dr. James F., St. Louis Park Medical Center, Minneapolis, Minn	40
Rosan, Dr. Jay, associate medical director, Health Maintenance Organization of Pennsylvania, Willow Grove, Pa	51
Coe, Gerald L., acting executive vice president/chief counsel, Group Health Cooperative of Puget Sound, Seattle, Wash.; accompanied by Merwyn R. Greenlick, director, Health Services Research Center, Kaiser Foundation Health Plan, Inc., Portland, Oreg., Dr. Russell F. Lewis, medical director, Greater Marshfield Community Health Plan, Marshfield, Wis., and John P. O'Connell, executive director, Fallon Community Health Plan, Worcester, Mass	63

MATERIAL SUBMITTED FOR THE RECORD

Briefing material for hearing: HMO's and other prepaid health plans	109
Statement of Paul M. Ellwood, Jr., M.D., president, InterStudy, Minneapolis, Minn	116
Statement of Samuel L. Havens, president, PruCare, and vice president, group insurance, Prudential Insurance Co. of America	121

MEDICARE REIMBURSEMENT TO COMPETITIVE MEDICAL PLANS

WEDNESDAY, JULY 29, 1981

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The committee met, pursuant to notice, at 2:10 p.m., in room 5110, Dirksen Senate Office Building, Washington, D.C., Hon. John Heinz, chairman, presiding.

Present: Senators Heinz, Cohen, and Grassley.

Also present: John C. Rother, staff director and chief counsel; Eileen Barbera, Ann Langley, and Eugene Scanzera, professional staff members; Kathleen M. Deignan, minority professional staff member; Ann Gropp, communications director; Robin L. Kropf, chief clerk; Nancy Mickey, clerical assistant; and Eugene R. Cummings, printing assistant.

OPENING STATEMENT BY SENATOR JOHN HEINZ, CHAIRMAN

Senator HEINZ. This afternoon's hearing is to examine the potential impact of reforming medicare reimbursement to HMO's and other prepaid health plans, for medicare beneficiaries and providers associated with these plans.

I've introduced, along with my distinguished colleagues, Senators Cohen, Chiles, Melcher, and Moynihan, the Competitive Health and Medical Plan Act, or CHAMP Act, which is designed to change medicare reimbursement to HMO's, and to enable other prepaid health benefit plans to participate in the medicare program. All such prepaid physician-insurer contractual arrangements under our bill are called competitive medical plans, or CMP's. Under the CHAMP bill, all CMP's would be reimbursed prospectively, in advance, for the medicare beneficiaries they serve—a reimbursement method which is consistent with the way these plans do business.

In today's hearing, we will focus on three specific aspects in particular of reforming medicare in the manner proposed by the CHAMP bill.

We will look at the benefits that accrue to medicare consumers who enroll in competitive medical plans.

We will look at the difference from the physician's perspective, between treating the elderly in a CMP and the fee-for-service system.

And finally, we will look at the results to date of a number of demonstrations being conducted by the Health Care Financing Administration, the purpose of which is to test various reforms in medicare payment to HMO's and IPA's.

In order to save time I am going to abbreviate my statement and I ask unanimous consent that my full statement be placed in the record.

[The prepared statement of Senator Heinz follows:]

PREPARED STATEMENT OF SENATOR JOHN HEINZ

This afternoon's hearing is to examine the potential impact of reforming medicare reimbursement to HMO's and other prepaid health plans, on medicare beneficiaries and providers associated with these plans.

I've introduced, along with my distinguished colleagues Senators Cohen, Chiles, Melcher, and Moynihan, the Competitive Health and Medical Plan Act, or CHAMP Act, which is designed to change medicare reimbursement to HMO's, and to enable other prepaid health benefit plans to participate in the medicare program. All such prepaid physician-insurer contractual arrangements under our bill are called competitive medical plans, or CMP's. Under the CHAMP bill, all CMP's would be reimbursed, prospectively, in advance for the medicare beneficiaries they serve—a reimbursement method which is consistent with the way these plans do business.

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And finally, we will look at the results to date of a number of demonstrations being conducted by the Health Care Financing Administration, the purpose of which is to test various reforms in medicare payment to HMO's and IPA's.

I might also note that the Health Subcommittee of the Finance Committee has scheduled a hearing for 2. p.m. tomorrow that will focus on specific prospective financing mechanisms for medicare and medicaid.

The CHAMP legislation represents a vital first step in reforming medicare to address two growing problems with the program—skyrocketing costs and shrinking benefits.

The public cost of treating our Nation's elderly continues to double approximately every 4 years. The Social Security Trustees recently reported that if no action is taken to arrest this trend, the medicare trust fund may go broke as early as 1989.

For these soaring costs, the elderly health care consumer will get little more in the way of benefits than he or she does today.

As a matter of fact, the elderly and disabled covered by medicare continue to be asked to dig deeper into their pockets to help pay the escalating costs of medicare. On July 1 of this year, the Health Care Financing Administration raised the monthly premium for medicare part B from $9.60 to $11, or about 14.6 percent. This increase came close on the heels of a 13.3-percent hike in part A, hospital insurance deductible (from $180 to $204) that the elderly and disabled began paying January 1 of this year.

Perhaps the most telling fact of all is that medicare covers only about 38 percent of the elderly's medical costs.

As medicare reimbursement rates decline, so does the number of physicians willing to participate in the program. Consequently, the ability of the elderly to select their physician is steadily diminishing. The assignment rate today is 51 percent—down from 61 percent just 10 years ago.

Congress must act now to get more and better health care for every medicare dollar. Doing so is vital to meeting the growing health care needs of older Americans today and in the decades ahead. In particular, we must begin to reverse the incentives contributing to soaring costs.

The CHAMP bill represents an important beginning to achieve these goals. It will not solve all of the problems faced by the Nation's elderly, nor is it intended to, but it is critically important that we begin to address these issues.

This reform is designed to encourage a continuity of care that is so often lacking when an elderly individual seeks treatment in the existing system. The CHAMP bill will enable the elderly to voluntarily participate in plans that eliminate the cumbersome claims reimbursement procedures, and that offer expanded health benefit plans for less out-of-pocket costs. And, the prepayment mechanism discourages unnecessary hospitalization, while providing an incentive for the most appropriate care.

This is a move we can make that will save money without any sacrifice in the quality of care. Within the last 1½ years, the Health Care Financing Administration has sponsored a number of demonstration projects to test prospective medicare

reimbursement to HMO's, IPA's, and other prepaid plans. The results to date show promise, although the demonstrations have identified some problems that we will address in hearings today and tomorrow. It is my understanding that one thing the demonstrations are unquestionably finding is that many elderly consumers are attracted to plans that can provide broader benefits in exchange for receiving all of their care from certain, efficient providers.

I look forward today to hearing firsthand the experience of those involved with both these demonstrations, and with other CMP's that serve medicare beneficiaries.

Senator HEINZ. I will just note that the medicare program is facing some very serious problems. The cost of it has been doubling every 4 years. Yet in spite of the increase in cost, medicare beneficiaries are paying a higher and higher percentage of their total health care costs.

Physician participation in the medicare program is steadily dropping. It was 61 percent 10 years ago. It is now down to 51 percent.

Congress needs to get into the act very quickly. I believe that Congress must act now to get more and better health care for every medicare dollar and that doing so is vital to meeting those growing health care needs of older Americans, not only today but in the decades ahead. In particular, I believe that we have to reverse the incentives contributing to soaring costs.

That is where we believe the CHAMP bill can make a major contribution. I have great hopes for the legislation. I think it offers the opportunity to expand health care at a lower per unit cost.

I, therefore, believe we can save money and give greater choice and more quality care to our senior citizens.

I look forward today to hearing, firsthand, the experience of those who have been involved in the demonstration, those who have been there as beneficiaries, those as providers, and those who have been there as students of both.

Senator Lawton Chiles, the ranking minority member of our committee, is unable to be with us today because of a prior commitment. He has submitted a statement for the record, and without objection, it will be inserted into the record at this point.

[The prepared statement of Senator Chiles follows:]

STATEMENT OF SENATOR LAWTON CHILES

I want to congratulate Senator Heinz for holding this hearing today—and for the leadership he has taken on this issue of medicare reimbursement to health maintenance organizations.

I am glad to join with him as a cosponsor of S. 1509, the Competitive Health and Medical Plan Act.

This bill is very similar to one both Senator Heinz and I, as well as other Aging Committee colleagues, sponsored during the last Congress. We had a lot of good support in the Senate then, and I have a feeling we will have even more this year.

As health care costs—and out-of-pocket medical expenses for the elderly—continue to rise, we continually search for alternative ways of delivering health care which can combat this inflation.

The experience of health maintenance organizations in general in controlling health care costs has been very favorable.

During the last few years, we have also seen that some experiments with medicare prospective reimbursement to health maintenance organizations have been very successful. The overall cost to the medicare program has been reduced—and in many cases, medicare beneficiaries are receiving *more* coverage than they had before joining the health maintenance organization.

That is what we want to see happen on a much broader scale, and I hope these hearings will contribute to a much better understanding of the opportunity we have to cut medicare costs and improve coverage if this concept is carefully developed.

Senator HEINZ. We have a panel of witnesses that I will call on.

Before I do that, I want to recognize the extremely active and most effective member of this committee, Senator Bill Cohen of Maine.

STATEMENT BY SENATOR WILLIAM S. COHEN

Senator COHEN. As you pointed out, we have some time constraints. We are about to vote on another amendment and perhaps even final passage of the tax bill by 3 o'clock.

So I ask that my formal statement be included in the record.

I share the chairman's alarm as to what is happening with skyrocketing costs for medicare. We pay now more for medicare than any other country in the world. The Public Citizens Health Research Group found that the elderly now pay an average of 70 cents on the dollar for physicians services. As a result, many older people do not seek medical help simply because they cannot afford it.

I want to commend Chairman Heinz for taking a very, very aggressive role in the whole field of health care and commend him for initiating the hearings.

I look forward to the testimony of the witnesses.

[The prepared statement of Senator Cohen follows:]

PREPARED STATEMENT OF SENATOR WILLIAM S. COHEN

It is no secret that health care costs in this country are skyrocketing. Despite our efforts to control rising medical costs, it is a sad fact that we have failed in this effort. As a result, Americans pay more for health care than any other country in the world.

For the elderly, health care costs have grown at a frightening rate. A recent study by Public Citizens Health Research Group showed that the elderly now pay an average of 70 cents on the dollar for physician services. Consequently, many older people do not seek medical help when they need it simply because they cannot afford it.

Medicare, which was launched over 20 years ago as the prime health insurer for the elderly, has been unable to relieve much of the financial burden of older Americans. Today, medicare pays only about 30 percent of the average older citizen's doctor bills, and only 38 percent of all medical bills—for hospitalization as well as doctor fees—incurred by senior citizens.

In most cases, the physician bills the patient directly for the balance of any medical costs. Thus, many older people end up spending more of their medical costs than originally envisioned by medicare advocates.

This problem is compounded by the fact that fewer and fewer doctors are willing to accept the assigned medicare fee as total payment for services. The assignment rate today is about 10 percent below what it was only 10 years ago. Today, American doctors now accept assignment on only half their fees. As a result, our older citizens have less choice and pay more for their health care services.

Earlier this month, I joined Senator Heinz in cosponsoring legislation which I believe addresses the problem of choice for our older Americans in selecting a health delivery system. This legislation would reform the method of reimbursement to health maintenance organizations (HMO's), and provide medicare reimbursement to certain prepaid health benefit plans. This concept of expanding prepaid plans under medicare could help control health care costs and possibly alleviate the strain on the medicare trust fund.

I commend the chairman for scheduling this hearing today. I look forward to hearing the witnesses speak directly of their experiences and their views on reimbursement options, beneficiary acceptance, benefits expansion, and the concept of competition in the medicare program.

Senator HEINZ. Thank you.

Our first panel of witnesses today is a panel of consumers of health care, we might say. They consist of George Kay, and George Voita, who is accompanied by his wife, Ruth. The latter are from St. Paul, Minn. Senator Durenberger, who is a member of this

committee, and saw me at lunch, asked me if I could welcome you here. He has a hearing which he has to Chair right at the same time. We often get pulled several ways at the same time and he would like me to welcome you to the committee on his behalf, and I do so.

We are glad to have you come this far. We appreciate the travel, not that Worcester, Mass., is right around the corner, either.

We thank you, Mr. Kay, for being here today. Mr. Kay, would you like to be our leadoff?

STATEMENT OF GEORGE H. KAY, BENEFICIARY, FALLON COMMUNITY HEALTH PLAN, WORCESTER, MASS.

Mr. KAY. I am George H. Kay, of Worcester, Mass. I am 72 years old and have lived in central Massachusetts all of my life.

I am a small businessman. I have been a member of the Fallon Community Health Plan/Senior Plan since May 1980.

Before joining the program, I was covered by the Blue Cross/Blue Shield Medicare Extension Certificate, known as Medex. My decision to join the Fallon Community Health Plan was made after I received descriptive literature and a dual choice card in the mail from Blue Cross. I attended an open house at the Fallon Clinic on a Sunday afternoon where the total program was carefully explained.

I understood that I was entitled to a broad range of benefits. I also understood that, except in cases of emergency, I would have to seek care through the Fallon Clinic. This was quite acceptable to me because it was convenient to my home and because Fallon offers a full range of health care services at one location. They have a wide variety of specialists and a full range of other services, such as laboratory, X-ray, pharmacy, and an eyeglass dispensary. I believe that it is really incredible that I can get all of these benefits for only $7.50 a month and that for this I can receive my care at a facility with such a good reputation.

Let me tell you about my condition. I have hemochromatosis. It is hereditary and I have probably had it all my life. I was disabled for about 8 years before I became a plan member. I was not able to work and I was in a great deal of pain. I have been under the care of numerous physicians, and I was hospitalized for 11 days, all to no avail. Medical expenses were a big problem, and I was simply not able to enjoy living.

When I became a plan member, I saw Dr. Robert A. Yood, a specialist at the Fallon Clinic, for a complete physical examination. He discovered my condition. It is a rare and unusual disease characterized by excess iron in the system. Since becoming a plan member, I have been under continuous care. Each week I undergo treatment known as phlebotomies where one pint of my blood is extracted, thereby diluting the iron in my system. Today I feel like a new person and I think I can work another 10 to 15 years.

As a plan member, I have made numerous visits to the Fallon Clinic. I have also received services on referral. I have been hospitalized. I have received prescription medications, and I have received an eye examination and eyeglasses from the clinic. During all this time, and for all these services, I have paid only the $7.50 per month and a $1 copayment for each prescription.

I would like to point out that at least 20 percent of all my physician services would not have been covered by medicare. In addition, there is a deductible charge for both hospital and medical services. I have saved about $15 a month from what I would have paid for Medex. My pharmacy and eyeglasses would not have been covered at all. Without the treatment that I received, I would not be gainfully employed as I now am.

In conclusion, the care is good. The price is right. The service is wonderful and I hope that this program is made available to everyone in the country.

Thank you for having me here today.

Senator HEINZ. Mr. Kay, thank you very much.

Mr. Voita.

STATEMENT OF GEORGE VOITA, BENEFICIARY, SHARE HEALTH PLAN, ST. PAUL, MINN., ACCOMPANIED BY RUTH VOITA

Mr. VOITA. Thank you, Mr. Chairman, for the opportunity to testify before the Senate Committee on Aging regarding health maintenance organizations contracting with medicare to provide benefits and services.

I am George Voita of West St. Paul, and this is my wife, Ruth Voita. I am retired and we both have medicare parts A and B. We joined SHARE January 1, 1981, which is one of the four HMO's in the demonstration project in the Twin Cities. There are 5,000 members in the SHARE senior care program and a total of 40,000 members enrolled in SHARE health plan. We are also both members of the Metropolitan Senior Federation and have been on the federation's HMO task force which has evaluated HMO's coordinating with medicare benefits and services.

Being a member of an HMO relieves me of the confusing paperwork of the medicare filing process. It's a problem playing round-robin with all the bills and forms in the traditional fee-for-service system. Under the old system, I receive the bill from the doctor, a form from medicare, and a form from the insurance company. By the time I sort out the forms and who pays what costs, I'm confused.

Taking care of the paperwork is one of the greatest things about HMO's for older people. Occasionally the doctor forgets to submit the forms to medicare and must be reminded. It could take several months to get the bill taken care of. Taking care of the paperwork is one of the greatest things about HMO's for older people.

There are financial advantages to being a member of an HMO. There are no deductibles and no coinsurance—we only have to pay the quarterly premium payment of $44.85 each, which includes unlimited doctor and hospital services. I know what my total health costs will be. We are able to budget our medical costs and that is important on a fixed income. There are no surprises.

There are increased benefits in the SHARE program that I would otherwise have to pay myself, in the traditional fee-for-service medicare system. I would expect to pay $120 for a routine physical examination; $60 for an eye examination; and $150 for a hearing examination. This is a total of $330 which I don't have to pay, in belonging to an HMO. While I don't have to have these

services every year, I know that they are available to me if I need them, and that's reassuring.

Since I am not concerned about the cost of every visit, I am more comfortable going to the doctor if I have to, which is the idea of the HMO concept. If I have a medical problem, I can go to the doctor for treatment while it is still a minor problem without worrying about the cost. If I were in the fee-for-service program I'd want to be very sure I had a medical problem before going to the doctor and then might wait too long before going. Even then, I'd be frustrated for spending $10 to find out I'm not sick. Keeping the member healthy is important in an HMO, and the doctors want to treat symptoms while they are still minor and not major medical problems.

Being a member of SHARE also means using the SHARE doctors only, except in emergency or when referred. I don't feel limited using the HMO doctors. My wife and I went to one doctor for a good many years under the traditional fee-for-service system, and reached a point where we felt he wasn't the only doctor who could give us good care. I feel better going to SHARE which has several doctors at each clinic and being able to get a second opinion. There are also some specialists on the staff. Having the many doctors available to me is better than just one family doctor. My experience is that the SHARE doctors do refer to a specialist if necessary. When I needed a referral, I was particularly impressed that they referred me to what I consider one of the top clinics in the area.

In summary, I like being a member of the SHARE senior care program for medicare beneficiaries because it takes care of my health care needs. Since there is no paperwork, I only receive a quarterly bill. I no longer have to deal with the complicated medicare filing process system.

I know what my premium and copayments are going to be so I can now budget my health care costs.

I no longer hesitate going to the doctor if I do not feel well because I know it will not cost me anymore than I have already paid.

Thank you again, Mr. Chairman, for this opportunity to express myself.

Senator HEINZ. Mr. Voita, thank you.

Mrs. Voita, we are glad you are here. If you want to add anything to what your husband has to say, please feel free to do so.

Gentlemen and Mrs. Voita, the reason we asked you here today is because you were participating in two of the four HCFA demonstration plans where, in effect, medicare is reimbursing IPA's or HMO's prospectively.

Both of you have testified that you liked the kind of health care you are receiving. You, Mr. Kay, mentioned the fact that you felt you got very good value for your money. You get the services of the pharmacy, and eyeglasses. Neither of those are available under medicare. There is no free drug program under medicare.

You, Mr. Voita, feel that you can get really better physician attention, if I understand what you said. I am wondering if most of your fellow members, people who participate along with you, feel pretty much the same way?

Are they generally satisfied, or are you unique?

Mr. KAY. No; I have yet to meet a member that has even shown any dissatisfaction. After what I went through, I can't recommend it too highly.

It is unbelievable.

Senator HEINZ. Mr. Voita.

Mr. VOITA. I think we find, and one of the reasons we joined SHARE, is that everybody that was in SHARE was so enthusiastic about it. Even now, we meet people who have been in the SHARE group program previous to the origination of their senior plan, they, too, have been happy.

Senator HEINZ. What was it that people told you that attracted you to the SHARE plan?

Mr. VOITA. I think one of the things, of course, is the economy of it, and the second is the apparent friendliness of the clinic, the ready availability of the doctors, the ready availability of referrals when needed, and also the fact that they do put on some health education seminars which sort of try to help us keep healthy.

Senator HEINZ. Now was that what attracted you before you got into the plan? Was it those factors or did you find out about those factors after you got into the plan?

Mr. VOITA. I think they did a very good marketing job. I think the man that presented the plan to us at a community meeting, and they schedule them throughout the community, during the establishment of the demonstration project—that we were so impressed that we signed up at that meeting.

Senator HEINZ. Mr. Kay, you have mentioned a number of benefits you feel you get.

What was it, though, that attracted you to go from your fee-for-service plan to this one?

Mr. KAY. Well, I say the greatest thing is the group of specialists that were employed by the Fallon Clinic. After all, if you go many years and you are continually getting worse, you cannot hold a screwdriver in your hand because your hands are so swollen, you can't walk because your knees are so swollen, then you go there and someone picks it up just like that, you have pretty good faith in an outfit like that.

Senator HEINZ. Well, that is quite a testimonial.

One of the things that people worry a little about an HMO is that you cannot shop around. You cannot go outside of the system and go to any specialist you want.

You cannot pick any doctor that you want to go to. You take the one that is available when he or she is there. That is called the lock-in provision.

From what I can tell in your testimony, changing from the fee-for-service system where you have no lock-in penalty, you seem to have made that transition relatively well. As a matter of fact, hearing both of you talk, it seems that you feel the contrary, you have really gotten more freedom of opinion, in a sense, from doctors, but have you at any point felt any difficulty, maybe in the beginning, adjusting to the so-called lock-in, giving up your family physician and going to someone who is a stranger?

Mr. KAY. No, I haven't.

Of course, what I recognized I think more than anyone else is that these men are trained and they know the people that are

specialists a lot better than you do by hearsay. When I got a man that picked out what was wrong with me and he performed what he was doing, then I had to have a liver biopsy and the heart condition—they were specialists that he turned me over to for those particular things.

I wouldn't know those specialists. How would I pick out that doctor. This is a case where they know a lot more than I do. I would rather take their advice.

Senator HEINZ. Mr. Voita, you and Mrs. Voita, to the best of my knowledge, had no specific health complaint when the opportunity came up?

Mr. VOITA. No, not really.

Senator HEINZ. Maybe Mr. Kay is a special case. He has a special disease.

What about your situation?

Mr. VOITA. I think when we made the change from the fee-for-service program that we had certain apprehensions. These are major decisions, but we decided to go that route, and the promptness with which we were able to get appointments, the promptness with which we could get our full physical without a separate fee and the promptness with which we could make an appointment and get referred to a specialist—I had a hearing problem. I got an appointment one day with SHARE. On the way home from SHARE I called the clinic that they referred me to and at 11 o'clock the next morning I was in the clinic getting a thorough hearing check, and had been fitted with the necessary hearing aid and at no cost to me except for the instrument.

Senator HEINZ. Well, thank you.

Senator Cohen.

Senator COHEN. Thank you, Mr. Chairman.

Mr. Kay, as I recall, you indicated you were 72 years old and you plan on working another 10 or 12 years.

I think the chairman might be interested in calling you back to another hearing and talking about retirement age and social security age. You would be one of our key witnesses.

Mr. KAY. Eight years ago I would have said different. Now I feel just as good as I did 15 years ago.

Senator HEINZ. I want to know who his doctor is.

Senator COHEN. Mr. Kay, I just want to make one point.

While the testimony that you and Mr. Voita have given this afternoon is very impressive, what you are saying in essence is that you are getting more for less. But you are also saying that you are getting better for less.

I am not sure that we can make that generalization for each and every case, that you will get better treatment for less money, because you happened to find a physician who diagnosed your case right away.

I suppose I could make the argument that you live in a State that is highly renowned for its medical facilities. The city of Boston has one of the finest medical facilities in the State of Massachusetts. So you might pick a physician that didn't diagnose your condition but the next time you might find one who did.

But by going to the HMO, I hope we are not suggesting that you get better treatment. I don't think that it necessarily follows.

Mr. KAY. You have a better average. You have more ranges, so you have a better chance.

Senator COHEN. Would it be available if you went to a physician——

Mr. KAY. I went to many a physician before.

Senator COHEN. Let me suggest that I am not an expert. But if I know a fellow in Boston who is a specialist in this field and I am going to refer you to him, theoretically he could have sent you to a person that diagnosed your condition. You had a series of doctors who did not, but I want to be careful we do not to overgeneralize.

You have a remarkable case but I do not want to make the flat generalization that we can always get more for less. I would hope that is the case, but it doesn't necessarily follow that it is.

Mr. Voita, how many times have you gone to an HMO since you joined in January 1981?

Mr. VOITA. I believe I have been there three or four times, and I believe Mrs. Voita has been there——

Mrs. VOITA. Once.

Senator COHEN. How does that compare with 1980?

You indicated there is a certain deterrent factor in the fee-for-service, namely, if there is a cost involved, you might have a minor complaint that might not be worth going to the doctor, but it might get worse. So there is an anti-incentive or disincentive to go to the doctor. So you were really not engaging in preventive practices.

What you are suggesting is that you know the service is there, and it is not going to be abused or overabused, but you are not overloading the system. The fact that it is there gives you reassurance.

How does that compare with 1980, or 1979?

Mrs. VOITA. I have been quite well, so I have not been to a doctor very often. I think my husband has gone more often since he has been going to SHARE than he did otherwise.

Mr. VOITA. I do not believe I went to a doctor in 1980. So I, too, have been quite well.

Senator COHEN. I think those are the only questions I have—did you feel a deterrent factor prior to the SHARE plan? Did you feel inhibited?

In other words, are you now utilizing the service you——

Mr. VOITA. Yes.

Under the fee-for-service program, under the usual insurance program, you either have a deductible before you pay your bills so that your usual routine visit to a doctor is coming out of your pocket and the routine visit does not come out of my pocket anymore.

Mr. KAY. Myself, I have had approximately, in the year and a half, approximately 70 visits and I must go at least once a week to take out a pint of blood, and that is going to keep up for 4 years.

That is over 6 gallons a year. It is a bloody situation.

Senator HEINZ. I am tempted to ask if there is someone who is suffering from anemia of your blood type.

Mr. KAY. My sister is suffering from anemia and needs my blood badly, but in Massachusetts it is controlled by the Red Cross and they will not allow my blood to be used. It is perfect blood except that it is loaded with iron.

Senator HEINZ. That may be beyond the control of this committee, but we will try to get Senator Kennedy interested in that.

Mrs. VOITA. The only disadvantage is having to go to the clinic. If you are away from home, it is a little more complicated.

Senator HEINZ. I gather that the lack of paperwork that you stress, Mr. Voita, is a considerably, tremendous advantage.

Mr. Kay, do you notice a little bit of a difference?

Mr. KAY. I do not even sign my name anymore.

Senator HEINZ. That is different.

Mr. KAY. Nothing to sign. It is a fabulous setup, I will tell you that.

Mr. VOITA. I think the problem with handling the forms, we do some volunteer work, telephone work, and in talking to a lot of the older folks, they get very confused with trying to sort out these forms, and we oftentimes find that this is very disconcerting to them.

Senator HEINZ. Mr. Kay, Mr. Voita, I am not sure we have any further comments.

We would like to thank you very, very much. You have given us a real consumer's eye view of what it is like to be in two of these four plans.

We thank you very much.

Our next witnesses are James M. Hacking and Jacob Clayman.

Gentlemen, welcome back. You are not at all unfamiliar to this committee or to this room

Mr. Hacking, would you start off, please?

STATEMENT OF JAMES M. HACKING, WASHINGTON, D.C., ASSISTANT LEGISLATIVE COUNSEL, NATIONAL RETIRED TEACHERS ASSOCIATION/AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. HACKING. Thank you, Mr. Chairman.

I am the assistant legislative counsel for the National Retired Teachers Association, and the American Association of Retired Persons.

As I am sure you are aware, these organizations have a combined membership now in excess of 13 million persons age 55 and older. Accompanying me is my colleague, Mr. Hagen.

As representatives of the associations, we welcome opportunity to stress the organizations' complete and full support for your bill and Senator Cohen's bill, S. 1509.

Clearly, we feel that the medicare program in general, and its reimbursement methodology in particular are in need of substantial revision to make prepaid health care a viable option for all Americans—including our growing elderly population. For the most part, older Americans as medicare beneficiaries, today, are excluded from HMO enrollment. This makes little sense and is cost promoting to the Federal Government and beneficiaries.

We would contend, given the substantial burden rapidly rising health care costs place on the elderly as well as the demonstrated record of success of HMO's in providing a highly comprehensive benefits package while containing health care costs, that legislation providing reimbursement under medicare for HMO's on the basis of a prospectively determined per capita amount is overdue. Our

associations have long endorsed, most recently in the 96th Congress—H.R. 4000, section 24—legislation which would allow for prospective reimbursement at rates related to the cost of providing medicare benefits to beneficiaries outside the HMO in the fee-for-service cost-based system at 95 percent of the average adjusted per capita cost.

We believe the CHAMP Act of 1981 to be reflective of these views and likely to establish for the first time prepaid health care as a truly viable health care option for the elderly.

It is widely accepted that prepaid health care in a truly competitive environment is the most rational approach to restructuring our Nation's health care delivery system. HMO's in particular offer comprehensive maintenance of health care with a payment mechanism that emphasizes health rather than the provision of services. In this sense, HMO's have substantial advantages for the aged and nonaged alike, including: (1) A proven ability to reduce hospital admissions; (2) the ability to provide accessible, comprehensive services, and continuity of care; (3) reduced out-of-pocket payments; (4) health promotion and maintenance incentives; (5) simplified claims procedures—for both providers and beneficiaries; (6) demonstrated quality of care; and (7) the introduction of competition into an otherwise unbridled and cost promoting health care marketplace.

Unfortunately, as of July 1980, the medicare program had only 38 cost contracts and 1 risk contract signed with HMO's serving approximately 61,500 enrollees—or less than 1 percent of the total medicare population. This lack of HMO penetration into the over 65 population can clearly be traced, in part, to current medicare reimbursement practices. Under present law, while HMO's can choose between risk or cost-based reimbursement, HMO's have generally found the risk reimbursement formula unacceptable because retroactive adjustments are made.

At the same time, if the HMO chooses cost reimbursement it must awkwardly graft a different reimbursement system onto its normal financial operations which are geared in its nonmedicare business toward a prospectively determined payment per enrollee and not related to the amount of care provided. Currently, if an HMO chooses a risk contract, it must not only fill out the necessary cost reports but also be federally qualified. The HMO will also run the more obvious risk of adverse selection.

Perhaps the most important feature of various legislative proposals dealing with HMO reimbursement reform is the provision that if medicare reimbursement—average per capita payment, based on the adjusted average per capita cost—exceeds the adjusted community rate for service under parts A and B or part B alone of medicare, the difference must be applied to additional benefits; decreased deductibles, premiums or copayments; or rebates—dividends—to enrollees. We believe that such additional benefits must be selected by the medicare beneficiaries themselves from a list of alternatives presented by the HMO. Assurances need to be provided that the HMO will retain only that portion of the average adjusted per capita cost that is equal to its adjusted community rate.

To encourage HMO participation in medicare these entities should be permitted to deviate from the community rating system to account for the special characteristics of its enrolled population. The HMO should not, however, be allowed to adjust for difference in health status within specific demographic groups or actuarial categories.

Our associations believe that the review of medical care or quality assurance is an important function of HMO's enrolling medicare beneficiaries. Presently, HCFA conducts no independent review of the quality assurance capability of HBO's with medicare contracts. Participating HMO's should be required to not only assess and assure quality care but also follow through on recommendations to enhance quality of care.

Furthermore, we believe that competitive medical plans or HMO's with which the Secretary of HHS contracts should have at least one-quarter of their membership consisting of nonmedicare and nonmedicaid individuals. The Secretary should have broad waiver authority in this regard in order to avoid unnecessary hardship. At the same time, ratios of premiums-to-benefits should be developed—collectively—for medicare beneficiaries to assure that their benefits are at least comparable to those of nonmedicare enrollees in the same health plan. Also, of special importance where HMO's adopt low and high option plans for medicare beneficiaries is the requirement that the HMO fully inform prospective enrollees of add-on services and charges—in addition to the basic benefit—charges for such items or services should not be allowed to exceed the adjusted community rate or charge to nonmedicare enrollees.

We also would contend that to ease the transition from an HMO which suffers financial insolvency—or for some other reason has its contract with HHS terminated—as well as to calm the fears of potential enrollees that the HMO be required to provide—and pay for—written notice to medicare beneficiaries well in advance of termination. This should include a description of alternatives for obtaining benefits.

Finally, we believe that a month-to-month option for medicare beneficiaries to terminate enrollment is adequate and should protect enrollees against any particular problems they may have in accessing quality health care services.

Any longer minimum enrollment periods should be avoided if medicare beneficiaries are to be attracted to the HMO option. In addition, the Secretary should be required to study any reimbursement changes with the focus logically being on the causes—and extent—of beneficiary disenrollment and the utilization as well as quantity and quality of health services received.

Of interest also, should be information on the additional benefits individual HMO's select to cover the difference between the AAPCC and the HMO's—actuarially adjusted—community rate. We also fully concur with the absence of a conversion factor in the CHAMP Act. Implementing a 1:2 or even 1:3 conversion ratio would unfairly penalize those medicare beneficiaries who are presently enrolled in HMO's on a cost basis. Such an approach of allowing a limited number of conversions from cost to risk formu-

las is not only inequitable but exceedingly complex from an administrative point of view.

While not adopting a conversion factor or ratio will add some small costs to any reform legislation, this will more than be made up in the significant reduction in hospital costs achieved by HMO's. This is particularly important in light of the precarious position of the medicare—hospital insurance—trust fund.

In summary, one of the major hurdles in establishing prepaid health care in general and HMO's in particular as a truly viable and cost-restraining option for our Nation's elderly is fashioning an effective marketing strategy. Merely identifying the local medicare population is a major problem for most HMO's. In addition to this, of course, is the cost of marketing to individual medicare beneficiaries. In this regard it is important that HCFA continue and in fact substantially expand its direct mailings to beneficiaries in HMO service areas. The message should continue to be informational in tone and factual, merely notifying the individual that there are one or more HMO's in their area serving medicare beneficiaries. As such, the message should not explicitly advocate HMO membership.

Moreover, in light of the significant costs of identifying and reaching this population and the fact that informative alternatives can only be disseminated in one-on-one presentations, prospectively determined reimbursement rates should allow HMO's to allocate marketing costs among programs on an enrollee basis so as to reflect the relatively greater cost of marketing aggressively to the medicare population.

Demonstrations thus far have shown that additional benefits and/or reduced premiums are a strong incentive for medicare beneficiaries to join an HMO. This finding essentially corroborates the observations of researchers studying employed HMO members that economic benefits are the chief attraction to joining an HMO. This incentive is recognized in the proposal to return to beneficiaries the difference between 95 percent of the AAPCC and the adjusted community rate in the form of additional benefits or reduced premiums.

Our associations believe that this approach is feasible, and we once again strongly support this reform. The real tradeoff for the beneficiary and as such the determinating factor in the success of this program, will be the willingness of the elderly to exchange increased services and reduced out-of-pocket liability for the complete freedom to choose their providers--primarily their physician. We would contend that while HMO's should not be mandated for special population groups such as the aged, with full knowledge beneficiaries will see the advantages of enrollment, that is, reduced out-of-pocket liability—at a time the elderly in particular can least afford the rising cost of health care—and a single access point to the health care delivery system.

Enrollment in HMO's is growing rapidly—up over 9 percent in the last year to more than 9.7 million members in some 246 plans—yet older Americans are benefiting little from this development as for the most part they are denied access to this health care alternative.

Even with the current reimbursement system our associations have repeatedly been approached by HMO's interested in reaching our members and in cooperatively marketing their plans. While we have not nor will we likely participate in such endeavors, we will continue to publicize the availability of the HMO option to our members where it is available and offered by responsible parties.

Most recently we printed an article in our news bulletins on the four HMO's in the Minneapolis-St. Paul area which are involved in a HCFA demonstration project enrolling medicare beneficiaries during a recently completed open enrollment period. In this somewhat atypical area the elderly were afforded the opportunity to enroll in either a low or high option plan at any of the four participating HMO's.

Membership in HMO's continues to be lowest among those over the age of 65. Yet surveys clearly show that the older the member of an HMO is the more likely he or she is to be very satisfied with the health care services being received. We strongly believe that this is largely a reflection of older Americans' collective inability to cope with the mounting costs of health care and their fervent desire to be better insulated against the cost of catastrophic illness.

Our associations support the Competitive Health and Medical Plan—CHAMP—Act of 1981, as an incremental and rational approach to an altogether irrational dilemma facing most older Americans—how to access quality health care services amidst cutbacks in Federal health care programs and an increasing inability to pay for the health care services and products they so desperately need.

That concludes my remarks, Mr. Chairman.

I thank you for this opportunity.

Senator HEINZ. Mr. Hacking, thank you very much.

[Testimony resumes on page 28.]

[The statement of the National Retired Teachers Association/American Association of Retired Persons follows:]

STATEMENT OF THE NATIONAL RETIRED TEACHERS ASSOCIATION
AND THE AMERICAN ASSOCIATION OF RETIRED PERSONS

Our Associations appreciate having the opportunity to be here today to offer our views on Medicare reimbursement of Health Maintenance Organizations (HMO's) and other prepaid health plans as well as the Competitive Health and Medical Plan (CHAMP) Act of 1981 (S.1509), recently introduced by Senator Heinz and co-sponsored by Senators Moynihan, Cohen, and Melcher. We offer these comments out of the conviction that the Medicare program in general and its reimbursement methodology in particular are in need of substantial revision to make pre-paid health care a viable option for all Americans - including our growing elderly population. For the most part older Americans as Medicare beneficiaries today are excluded from HMO enrollment. This makes little sense and is cost promoting to the Federal government and beneficiaries.

We would contend, given the substantial burden rapidly rising health care costs place on the elderly as well as the demonstrated record of success of HMO's in providing a highly comprehensive benefits package while containing health care costs, that legislation providing reimbursement under Medicare for HMO's on the basis of a prospectively determined per capita amount is overdue. Our Associations have long endorsed, most recently in the 96th Congress (HR 4000 - Section 24), legislation which would allow for prospective reimbursement at rates related to the cost of providing Medicare benefits to beneficiaries outside the HMO in the fee-for-service cost-based system (at 95% of the average adjusted per capita costs). We believe the CHAMP Act of 1981 to be reflective of these views and likely to establish for the first time prepaid health care as a truly viable health care option for the elderly.

Background

Health Maintenance Organizations (HMO's), while demonstrating a number of advantages, seem not to have completely fulfilled the hopes of their founders nor of the Congress. Still, it is widely accepted that prepaid health care in a truly competitive environment is the most rational approach to restructuring our nation's health care delivery system. HMO's in particular offer comprehensive health care with a payment mechanism that emphasizes health rather than the provision of services. In this sense HMO's have substantial advantages for the aged and non-aged alike, including: (1) a proven ability to reduce hospital admissions; (2) the ability to provide accessible, comprehensive services and continuity of care; (3) reduced out-of-pocket payments; (4) health promotion and maintenance incentives; (5) simplified claims procedures (for both providers and beneficiaries); (6) demonstrated quality of care; and (7) the introduction of competition into an otherwise unbridled and cost promoting health care sector. Despite these benefits, HMO's have been less than successful (or perhaps desirous) in attracting Medicare and Medicaid beneficiaries when compared to their efforts in the private sector. One of the major obstacles has been legislative barriers to prepaid, capitation reimbursement by the Medicare program. Experience with a number of recent demonstration projects suggests rather strongly, however, that incentives such as increased benefits and reduced cost sharing are highly effective in attracting the over-65 population at large to HMO's.[1/]

1/ Medicare at an estimated FY 1982 cost of $48 billion currently pays only 38% of the elderly's annual health bill.

And this will increasingly be the case as out-of-pocket liability for health care services continues to increase and Medicare benefits are pared back by the Congress in an effort to reduce program costs.

As individuals not associated with employee groups for the most part, access to HMO's and other forms of prepaid health care for our Medicare population has been spotty at best. As of July 1980, the Medicare program had only 38 cost contracts and one risk contract signed with HMO's serving approximately 61,500 enrollees - or less than 1% of the total Medicare population. This lack of HMO penetration into the over-65 population can clearly be traced, in part, to current Medicare reimbursement practices. Under present law, while HMO's can choose between risk or cost based reimbursement, HMO's have generally found the risk reimbursement formula unacceptable because retroactive adjustments are made. At the same time, if the HMO chooses cost reimbursement it must awkwardly graft a different reimbursement system onto its normal financial operations which are geared in its non-Medicare business toward a prospectively-determined payment per enrollee and not related to the amount of care provided. Currently, if an HMO chooses a risk contract it must not only fill out the necessary cost reports but also be Federally qualified. The HMO will also run the more obvious risk of adverse selection.

In addition to current reimbursement policies, another major impediment to developing HMO's as a realistic option for the elderly involves marketing. Unlike other enrollees, Medicare beneficiaries are not part of a group and therefore more difficult and costly for the HMO to reach. This is a very basic problem that needs to be addressed in Medicare reform legislation. In light of the extreme difficulty Medicare beneficiaries have in fully understanding their Medicare benefits and their perceived need for supplemental or "Medigap" health insurance, it

is particularly important that marketing information supplied during the open enrollment period be simple and to the point so that the beneficiary is not further confused by this additional HMO option where it is available. The Federal government, the Department of Health & Human Services (HHS), as well as organizations such as ours have obvious roles to play in such an undertaking.

The Competitive Health and Medical Plan (CHAMP) Act of 1981 and Other Reform Proposals

This bill (S.1509) is similar to a provision nearly approved in the 96th Congress as part of the deliberations on the Budget Reconciliation Act of 1980 (and reported as part of HR 4000). Our Associations continue to strongly support reimbursement reform such as that embodied in the CHAMP Act which would provide for the enrollment of Medicare beneficiaries in HMO's on the basis of a prospectively determined per capita rate for each class of individuals entitled to Medicare benefits and equal to 95% of the adjusted average per capita cost for that class. Those HMO's enrolling elderly Medicare beneficiaries would assume full financial risk while largely avoiding those retroactive adjustments that are part of the present risk formula and which severely limit HMO enrollment of the poor and the aged. Importantly, this legislation also departs from current law in defining a "competitive medical plan" or HMO as any public or private entity meeting the requirements of section 1310(d) of the Public Health Service Act, an entity licensed by a State as an HMO, or any entity organized and operated so that assurances are received as to: health care services to be provided; the capacity to bear potential loss while assuring a fiscally sound operation--with protections being afforded enrollees against

the risk of insolvency; fixed, periodic pre-payment without regard to the frequency, extent or kind of health care services actually provided; and the accessibility and availability of these services.

More specifically, our Associations believe that access to HMOs for Medicare beneficiaries is of such critical importance that it would be counterproductive and foolhardy to require that the HMO be Federally-qualified to participate in the Medicare program. There are certain basic standards for Federal qualifications in Title XIII of the Public Health Service Act (enumerated above) that have been retained in the CHAMP Act. Requiring the minimum set of benefits contained in this Title is ill-advised, however, since this benefit package is more generous than the current Medicare package, as well as that which many HMO's ordinarily provide.1/ This requirement if retained, might well discourage some HMO's from participating in Medicare. Still, the basic requirements of Title XIII are necessary since Medicare beneficiaries will be "locked-in" to the HMO for their health care services and they must be fully aware of where and when they can obtain services as well as their cost sharing liability and the nature or range of the benefits they will receive.

A particularly important provision of the CHAMP Act and generally lacking in previous legislation of this type is the 30-day open enrollment period which each "competitive medical plan"

1/ We believe that any legislation dealing with HMO reimbursement reform should retain the provision in Title XIII requiring equal and nondiscriminatory treatment of mental and physical illness. The Medicare benefits package already excessively discriminates against mental illness and the need for mental health services.

must have at least once a year. We are especially supportive of the requirement that the HMO accept "up to the limits of its capacity and without restrictions" Medicare beneficiaries in the order in which they apply--and without reference to any health screening or pre-existing conditions. Furthermore, the rapid termination provisions are highly appropriate as are the re-enrollment protections...the latter helping to avoid beneficial selection on the part of plans enrolling Medicare beneficiaries.

As in the case of the Federal Employees Health Benefits Plan (FEHBP), the open enrollment period and marketing efforts of the various competitive entities (HMO's) will be crucial to both the competing plan and the beneficiary. The Federal government, through the Secretary of HHS, has a central role to play here in assuring that Medicare beneficiaries are provided accurate, timely, and understandable information upon which to base such a major health care choice. In essence, the Congress and the Department must act as an advocate of the HMO much like an employer does with his employees[1/]. Passivity will only assure the status quo, especially for the elderly who utilize the health care system to a much greater degree than the nonelderly and who as a result are somewhat reluctant to make such a major change in how they secure their health care.

1/Of those joining HMO's for the first time only 7% do so without being associated with or going through their employer. See American Attitudes Toward Health Maintenance Organizations: A Survey of the Public, HMO Members, and Potential Members Nationwide, by Louis Harris and Associates Inc. for the Henry J. Kaiser Family Foundation, July 1980.

Perhaps the most important feature of various legislative proposals dealing with HMO reimbursement reform is the provision that if Medicare reimbursement (average per capita payment, based on the adjusted average per capita cost) exceeds the adjusted community rate for service under Parts A and B or Part B alone of Medicare, the difference must be applied to additional benefits; decreased deductibles, premiums or co-payments; or rebates (dividends) to enrollees. We believe that such additional benefits must be selected by the Medicare beneficiaries themselves from a list of alternatives presented by the HMO. Assurances need to be provided that the HMO will retain only that portion of the average adjusted per capita cost that is equal to its adjusted community rate. To encourage HMO participation in Medicare these entities should be permitted to deviate from the community rating system to account for the special characteristics of its enrolled population. The HMO should not, however, be allowed to adjust for difference in health status within specific demographic groups or actuarial categories.

Our Associations believe that the review of medical care or quality assurance is an important function of HMO's enrolling Medicare beneficiaries. Presently, HCFA conducts no independent review of the quality assurance capability of HMO's with Medicare contracts. Participating HMO's should be required to not only assess and assure quality care but also follow - through on recommendations to enhance quality of care.

Furthermore, we believe that competitive medical plans or HMO's with which the Secretary of HHS contracts should have at least one-quarter of their membership consisting of non-Medicare

and non-Medicaid individuals. The Secretary should have broad waiver authority in this regard in order to avoid unnecessary hardship. At the same time, ratios of premiums-to-benefits should be developed (collectively) for Medicare beneficiaries to assure that their benefits are at least comparable to those of non-Medicare enrollees in the same health plan. Also, of special importance where HMO's adopt low and high option plans for Medicare beneficiaries is the requirement that the HMO fully inform prospective enrollees of add-on services and charges (in addition to the basic benefit); charges for such items or services should not be allowed to exceed the adjusted community rate or charge to non-Medicare enrollees.

We also would contend that to ease the transition from an HMO which suffers financial insolvency (or for some other reason has its contract with HHS terminated) as well as to calm the fears of potential enrollees that the HMO be required to provide (and pay for) written notice to Medicare beneficiaries well in advance of termination. This should include a description of alternatives for obtaining benefits[1/].

Finally, we believe that a month-to-month option for Medicare beneficiaries to terminate enrollment is adequate and should protect enrollees against any particular problems they may have

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1/ Bonding and financial reserve (escrow) requirements do seem advisable to protect HMO members. This could be an important part of contracts between the HMO and their providers (especially hospitals). However, in light of the difficulties home health agencies are experiencing in fulfilling similar obligations we would hope that this issue would receive careful study prior to final consideration of HMO reform legislation.

in accessing quality health care services. Any longer minimum enrollment periods should be avoided if Medicare beneficiaries are to be attracted to the HMO option. In addition, the Secretary should be required to study any reimbursement changes with the focus logically being on the causes (and extent) of beneficiary disenrollment and the utilization as well as quantity and quality of health services received. Of interest also should be information on the additional benefits individual HMO's select to cover the difference between the AAPCC and the HMO's (actuarially adjusted) community rate. We also fully concur with the absence of a conversion factor in the CHAMP Act. Implementing a 1:2 or even 1:3 conversion ratio would unfairly penalize those Medicare beneficiaries who are presently enrolled in HMO's on a cost basis. Such an approach of allowing a limited number of conversions from cost to risk formulas is not only inequitable but exceedingly complex from an administrative point of view. While not adopting a conversion factor or ratio will add some small costs to any reform legislation, this will more than be made up in the significant reduction in hospital costs achieved by HMO's. This is particularly important in light of the precarious position of the Medicare (Hospital Insurance) Trust Fund[1/].

1/ The overall hospital inpatient utilization rate for all HMO plans in 1979 was 418 days per 1,000. This compares to a rate of 725 days per 1,000 Blue Cross/Blue Shield members over approximately the same time period. At an estimated cost of $288 per inpatient day and $2,046 in expenses per stay in 1981 it is easy to see the magnitude of potential cost savings to the HI Trust Fund implicit in increased HMO enrollment of Medicare beneficiaries.

Summary

One of the major hurdles in establishing prepaid health care in general and HMO's in particular as a truly viable and cost restraining option for our nation's elderly is fashioning an effective marketing strategy. Merely indentifying the local Medicare population is a major problem for most HMO's. In addition to this of course is the cost of marketing to individual Medicare beneficiaries. In this regard it is important that HCFA continue and in fact substantially expand its direct mailings to beneficiaries in HMO service areas. The message should continue to be informational in tone and factual, merely notifying the individual that there are one or more HMO's in their area serving Medicare beneficiaries. As such, the message should not explicitly advocate HMO membership. Moreover, in light of the significant costs of identifying and reaching this population and the fact that informative alternatives can only be disseminated in one-on-one presentations, prospectively determined reimbursement rates should allow HMO's to allocate marketing costs among programs on an enrollee basis so as to reflect the relatively greater cost of marketing aggressively to the Medicare population.

Demonstrations thus far have shown that additional benefits and/or reduced premiums are a strong incentive for Medicare beneficiaries to join an HMO. This finding essentially corroborates the observations of researchers studying employed HMO members that economic benefits are the chief attraction to joining an HMO. This incentive is recognized

in the proposal to return to beneficiaries the difference between 95 percent of the AAPCC and the adjusted community rate in the form of additional benefits or reduced premiums. Our Associations believe that this approach is reasible and we once again strongly support this reform. The real trade-off for the beneficiary and as such the determinating factor in the success of this program will be the willingness of the elderly to exchange increased services and reduced out-of-pocket liability for the complete freedom to choose their providers--primarily their physician. We would contend that while HMO's should not be mandated for special population groups such as the aged, with full knowledge beneficiaries will see the advantages of enrollment, i.e. reduced out-of-pocket liability (at a time the elderly in particular can least afford the rising cost of health care) and a single access point to the health care delivery system.

Enrollment in HMO's is growing rapidly--up over 9% in the last year to more than 9.7 million members in some 246 plans--yet older Americans are benefiting little from this development as for the most part they are denied access to this health care alternative. Even with the current reimbursement system our Associations have repeatedly been approached by HMO's interested in reaching our members and in cooperatively marketing their plans. While we have not nor will we likely participate in such endeavors, we will continue to publicize the availability of the HMO option to our members where it is available and offered by responsible parties. Most recently we printed an article in our Newsbulletins on the four HMO's in the Minneapolis -

St. Paul area which are involved in a HCFA demonstration project enrolling Medicare beneficiaries during a recently completed open enrollment period. In this somewhat atypical area the elderly were afforded the opportunity to enroll in either a low or high option plan at any of the four participating HMO's.[1/]

Membership in HMO's continues to be lowest among those over the age of 65. Yet surveys clearly show that the older the member of an HMO is the more likely he or she is to be very satisfied with the health care services being received. We strongly believe that this is largely a reflection of older Americans' collective inability to cope with the mounting costs of health care and their fervent desire to be better insulated against the cost catastrophic illness.

Our Associations support the Competitive Health and Medical Plan (CHAMP) Act of 1981 as a stepwise and rational approach to an altogether irrational dilemma facing most older Americans - how to access quality health care services amidst cutbacks in Federal health care programs and an increasing inability to pay for the health care services and products they so desperately need.

1/ The four plans involved in this project are: MedCenter Health Care, HMO Minnesota, Nicollet/Eitel, and Share Health Plan. The four participating plans currently have a total enrollment of 136,000, about 9% of the local health care market.

Senator HEINZ. Jake Clayman.

STATEMENT OF JACOB CLAYMAN, WASHINGTON, D.C., PRESIDENT, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. CLAYMAN. Mr. Chairman, Senator Cohen, I am absolutely amazed at the figures I heard this afternoon, $7.50 a month, $44 a quarter. I assume that applies to that portion of health care outside of the purview of medicare.

Even so, it is an amazing set of statistics.

Mr. Chairman, if the figures are real, and they obviously are in regard to the two witnesses, and if they are applicable across the country, I can suggest to you and Senator Cohen that over time we would get most of the senior citizens of America, at least the ones I know, into an HMO system.

There are three improvements that senior citizens seek in the field of health care. One is higher quality of care. Two, cheaper health care. And three, the development of a variety of competitive health care systems which will have the effect of raising the level of quality and lowering the cost of delivery of health care.

In my judgment, Senator Heinz, your bill makes a modest but positive step forward and takes a kind of general aim at the three objectives that I suggested.

The bill, in its plan to pay HMO's prospectively rather than retrospectively, is a definite encouragement to the creation and growth of such institutions and the idea, incidentally, fits in quite readily with the basic philosophy of HMO's in our country.

If HMO's prosper and multiply in the United States, at least in my perhaps uncritical judgment, health care delivery will make a quantum leap forward not only in reducing costs but raising the quality of health care in our country.

So, in our judgment, senior citizens need HMO's because they spend too much of their substance on health needs. The statistics in regard to the ordinary senior citizen bears no relationship whatsoever to the magnificent statistics that we listened to this afternoon.

The average senior citizen spends about $700 in cash out of his pocket every year, and that is in addition to medicare. And, incidentally, then medicaid costs are much higher than the rest of the population, some say three times as high. I cannot vouch for that figure, but I believe it to be sound. I have seen it in print.

Now, then, I think you know, that medicare is enormously significant in our society, a magnificent institution, even though from time to time someone wants to kick it around unjustly, in my judgment. Medicare provides roughly about 40 percent of medical costs which ordinary senior citizens bear in our country, which leaves, you see, 60 percent of that load strapped to the backs of millions of Americans, many of whom cannot bear, and many of them who cannot bear it are not likely to get medicaid, either. They may have incomes slightly above the level of medicaid requirements but still cannot afford the kind of costs that are involved.

In my judgment, and I will quit soon because I know that red eye stares from time to time—very intimidating.

Senator HEINZ. I cannot believe that anything would intimidate you, Jake.

Mr. CLAYMAN. I love you, too, Senator.

Now, where was I?

You see how you intimidate me?

Well, costs have been cut by HMO's, the kind that I have known over the years. They have increased the quality of medicine in my judgment. Not enough elderly citizens are involved in HMO's. I am told that only about 2 percent of seniors are actually enrolled in HMO's. It ought to be higher and your bill, in my humble judgment, tries to give a little more life to the institution we know as HMO's.

I think that perhaps I better quit before the light goes on. I want to cooperate with the Chair.

Senator HEINZ. Jake, you, as always, make an excellent contribution.

[Testimony resumes on page 38.]

[The prepared statement of Mr. Clayman follows:]

Statement by

Jacob Clayman
President

National Council of Senior Citizens
925 15th Street, N.W.
Washington, D.C. 20005

before the

United States Senate Special Committee on Aging

hearing on

Medicare Reimbursement to Competitive Medical Plans

July 29, 1981

Mr. Chairman, members of the Committee, I am Jacob Clayman, President of the National Council of Senior Citizens. The National Council represents nearly four million elderly persons throughout the country through 4,000 affiliated clubs and councils.

The National Council of Senior Citizens was created twenty years ago by a dedicated group of people deeply committed to the health care needs of the elderly. With the help of these dedicated NCSC founders the Medicare program was enacted.

Today, as we begin our twenty-first year, this commitment and dedication continue, guiding our activities as we work toward a better life for senior citizens. We are involved in many issues which affect the elderly, but one of our foremost goals is to meet the health care needs of the elderly.

I am very pleased, therefore, to speak to you about reforming Medicare reimbursement to Health Maintenance Organizations and certain other pre-paid health benefit plans. The NCSC believes that increased Medicare beneficiary enrollment in these plans should be encouraged. These plans address some of the serious deficiencies which exist in the Medicare program due to its basis in the fee-for-service reimbursement system.

The NCSC has long supported the development of health maintenance organizations and the appropriate Medicare reimbursement of these plans. We commend you, Mr. Chairman and members of the committee, for pursuing more efficient Medicare coverage of the HMO model and similar pre-paid entities. We believe that Medicare coverage of these plans on a pre-paid basis can bring significant benefits to Medicare beneficiaries as well as the health care system and the federal budget.

Why Medicare reimbursement of prepaid health benefit plans by capitation is necessary.

The problems the elderly encounter in pursuing adequate health care under the current system are well documented. On this subject representatives of NCSC have testified on numerous occasions before this and other Congressional committees. We have described the problems of high cost, inadequate health insurance coverage, overly-emphasized acute episodic care, and the lack of chronic and long-term care. Mr. Chairman, these very serious problems continue, and we feel that the traditional retrospective fee for service reimbursement system helps to perpetuate them.

In spite of these problems, Medicare beneficiaries have little choice but to be locked into an inefficient health care system. Although the federal government has encouraged the development of a competitive delivery system, and although the efficiencies of the HMO model have been proven, little has been done to encourage the elderly person to enroll in such a system. Today, only about two percent of Medicare beneficiaries belong to HMOs, and they do not benefit from choosing a more efficient system of care.

The HMO itself does not have a great incentive to enroll Medicare beneficiaries because of the current reimbursement policies. HMOs are reimbursed by Medicare on a retrospective fee-for-service basis, fundamentally inconsistent with the normal operation of an HMO.

The National Council of Senior Citizens feels that reforming Medicare reimbursement of pre-paid health plans can also address some of the problems in the present health care system. Based on retrospective fee-for-service reimbursement to health care providers, this system is inefficient, expensive, and it feeds inflation. Under the current system, we are spending more but not necessarily getting more for our money.

Today, the increasing costs are not accompanied by equivalent increases in quality. Instead, costs rise unabated because the system lacks incentives for providers to operate efficiently or for consumers to seek less expensive, equally beneficial systems of care.

The pre-paid system based on the HMO model, on the other hand, is inherently efficient and encourages savings without sacrificing quality. It has built in incentives to keep costs low and keep the patient well, incentives which are lacking in the fee-for-service system. The pre-paid system, therefore, has another significant function: to provide competition to the traditional system, moderating overall health care costs.

Finally, the federal budget will benefit from Medicare prospective reimbursement of pre-paid health care plans. These plans will save Medicare dollars, and the competition to the traditional fee-for-service system can save other health care dollars as well.

I would add that today too many public policy makers try to curb federal spending by cutting back programs and reducing benefits to people. This action is taken in spite of available reasonable alternatives. We are pleased that you, Mr. Chairman, and this committee are pursuing one of these reasonable alternatives: promoting efficiency in the health care system while offering the elderly the potential for expanded benefits and lower out of pocket expenses.

How Medicare reimbursement of pre-paid health benefit plans can help the elderly.

I will now discuss some of the benefits the elderly can receive through the reforms we are discussing here today.

The elderly spend a significant portion of their limited incomes for health care. The potential to save money and gain benefits will provide sufficient incentive for many elderly persons to join pre-paid health plans.

Medicare beneficiaries will be able to:

- Receive more of the type of health care they need but often do not receive through the current system.

  °The HMO model stresses preventive and non-institutional care when appropriate to keep the patient well and avoid giving unnecessary services. The current system emphasizes acute episodic care through institutionalization and/or high technology. The elderly's most frequent and often financially devastating health care needs are chronic and long-term care. The [illegible]iling system fails to meet these needs and meets the acute care needs in the most expensive manner possible.

- Budget their out-of-pocket health care expenditures more accurately.

  ° The pre-paid plan would be compensated without regard to the date, kind, extent, or frequency of service. This would lessen the burden on the beneficiary of unanticipated expenditures and charges for excessive fees.

  ° The problem of finding physicians who accept Medicare B assignment and of paying the excess fees of those who do not will also be lessened.

- Share in the savings when selecting a more efficient health care plan.

  ° Receiving additional benefits, and decreased deductibles or co-payments could significantly reduce the elderly's out of pocket expenses or allow them to receive certain services they may now forego because of the cost.

- Receive most of their health care in one co-ordinated facility with a unified medical record system and a focus on a continuum of care.

- Choose a health care delivery system which best suits their individual needs and circumstances.

- Receive health care without having to be burdened with the paperwork involved in filing claims for reimbursement.

Legislative Initiatives

We commend you, Mr. Chairman, for introducing legislation to reform Medicare reimbursement to HMO's and other pre-paid medical plans. We have studied your Competitive Health and Medical Plan, "CHAMP," and we consider it a significant step toward expanding the health care services and options available to the elderly. In addition, we are certain it will save money.

The CHAMP proposal will offer to the elderly the benefits I have already outlined. The elderly will benefit in other ways as well.

- Since CHAMP will reimburse pre-paid health plans in addition to federally qualified HMO's, the elderly's access to this health care alternative will be greatly expanded.

  ° However, we must be assured that the entities qualified under CHAMP are not only financially sound providers of quality care, but also will be able to fulfill the purposes of this plan.

  The definition of a qualifying plan must not be so broad as to allow highly specialized, or non-comprehensive plans to be reimbursed. Such plans may not meet the elderly's total health care needs and would be more expensive to both the Medicare program and the beneficiary. Thus, the purpose of the CHAMP program would be defeated. We therefore recommend restricting the eligible plans to those based on the HMO model--those who can provide services in addition to those covered by this bill.

- The CHAMP proposal contains a potential framework to develop organized long-term care policies. Such policies are lacking today, and are becoming more and more important as the population ages.

  ° As noted the present health care system fails to meet the elderly's total health care needs. It may meet the needs of the younger, healthier population by focusing on acute, episodic, short-term care, but the elderly need much more than this care.

The elderly have dynamic health care needs that occur on a continuum ranging from short-term to long-term, acute to chronic, and involving social and psychological as well as physical problems.

° The HMO model, through comprehensive and coordinated care, looks at the patient as a totality of needs. It is in this context that CHAMP can truly help the elderly.

The CHAMP bill is a very good start. If the basic elements of the bill could be expanded to develop long-term care policies according to the HMO model, the program could begin to meet the elderly's total health care needs. For example:

- CHAMP plans could be encouraged to develop the resources to better care for the growing elderly population.
- Funds could be made available for demonstration projects which focus on delivery systems to meet chronic and long-term care needs.

The National Council of Senior Citizens recommends that these provision be incorporated into the bill.

- Limit the pass back of savings to the beneficiary to expanded benefits or reduced premiums, co-payments or deductibles.

° Health care providers should be concerned with the quality of care they render, not the cash they return. To allow rebates or dividends would foster price competition instead of service competition among providers.

We believe that cash is not an equivalent substitute for expanded benefits. Allowing a cash passback would enable entities without comprehensive or preventive services to qualify, and the beneficiaries would be no better off than under the current system.

- Include preventive health services as a covered benefit.

° Preventing illness or treating illness in early stages is not only sound health care practice but it saves money by eliminating or reducing the need for more intensive or institutional services.

° These services are particularly important for the elderly's well-being. Such services enable the elderly person to remain more functional with reduced risk of complication from illness and hospitalization.

- Inform the Medicare beneficiary of his/her options to choose a competitive plan and the advantages and disadvantages of the current and proposed system.

  Medicare beneficiaries must be able to choose the plan best for them, based on full knowledge of the programs.

In summary, we need Medicare prospective reimbursement of pre-paid plans to expand benefits and options available to the elderly and to foster efficiency in the health care system. This reform of Medicare cannot take place without adequate protection of the Medicare beneficiary.

Senator HEINZ. Let me just give both you and anybody who is attentive, the clarification of the $7 a month, and the $44 a quarter referred to by our witnesses respectively. That is, to be totally accurate, above the $11 premium for part B that they do pay to HCFA.

In other words, all of them are paying for part B coverage. They write out their check. I do not know with what frequency, but the $11, in effect, goes to HCFA, and then the $44 and $7 goes to the HMO in this case, but even with those numbers it is still quite a considerable savings.

Mr. CLAYMAN. Absolutely right, and apparently they get the full range of health care, including hospitalization, and that is absolutely fantastic.

Senator HEINZ. Mr. Hacking, you touched, in your statement, on the plowback provision we have in the legislation. We have put that plowback in there in order to insure that any so-called excess profits realized by an HMO or a CMP would be plowed back into benefits or into reimbursements to the beneficiary.

The way it works is if an area average per capita cost reimbursement is more than the adjusted community rate, that plan is supposed to offer the equivalent value but it could include reduced copayments, and it could include a simple rebate.

We have heard testimony that indicated today, and we have had it from other sources looking at these HCFA demonstrations, that the existing demonstrations which have no such plowback requirement seem to be developing additional services, extra home health care coverage, nursing home days beyond what medicare covers.

We have had examples of eyeglasses, and prescriptions with a modest copayment.

So my question is this: There are some that do believe that the plowback provision need not be required by law, that it is unnecessary and indeed someone could argue that it is inherently anticompetitive.

Would you, in turn, I will ask this of you in turn, agree that these medical plans would expand benefits to attract medicare customers without the legislative mandate of the plowback to do so?

Mr. HACKING. Well, Senator, we would not want to run the risk that in the absence of this plowback feature that services, indeed, would be expanded and that enrollment would increase. We look upon this plowback feature as a strong incentive and we would rather see the legislation include it rather than exclude it, and see what happens.

The fact is that medical costs have been rising well in advance of the rate of inflation, in the economy in general. So the burden of out-of-pocket costs of the elderly and the total health bill of the elderly have been rapidly increasing. This plowback provision will provide an increasing incentive for enrollment in HMO's. We think it is a strong and desirable feature.

Senator HEINZ. Would you support the legislation if it did not have that feature?

Mr. HACKING. We will support legislation that will serve to expand the HMO option, but we think without the feature it would be less attractive. Nevertheless, it would still have our support.

Senator HEINZ. Jake.

Mr. CLAYMAN. I think I share that general feeling, that it is a plus and should be included. I do not know that it would vitiate the bill but it is an inducement.

Senator HEINZ. I think you made yourselves clear.

By the way, I note that you endorsed the bill as a modest positive step forward, but if it does all the things that you say it does, how can it be so modest?

Maybe it is a major step forward.

Mr. CLAYMAN. I am getting gun shy in this session of Congress and I hesitate to——

Senator HEINZ. First, you are intimidated and then you are gun shy.

Mr. CLAYMAN. Seriously, there is a real chance of getting the senior citizens involved in the program you have in mind, not so much that those who have retired are too readily looking to move into it. I have a hunch that the costs are somewhat beyond what we have heard today, at least in my own experience.

But there is a real opportunity to get those who are now working, approaching 65, no longer covered by whatever program they have in the labor management contract, and they can be induced, it seems to me, with a rational program, to become involved in the HMO's and if they do, I think we may see the beginning of a radical change in delivery of health care in America.

Senator HEINZ. Jake, thank you very much.

Senator Cohen.

Senator COHEN. Just one question, perhaps to Mr. Hacking.

Mr. Hacking, I notice in your prepared statement that you endorse the provision we have in our bill that would not require the HMO's to be federally qualified to participate by Federal standards, at least in the medicare program.

Over the past few years we have had a good deal of trouble as far as fraud and abuse in medicare and medicaid. We have had H.R. 3 which passed amendments to the Medicare-Medicaid Act. We have also had difficulties as far as defining the role of home-health care, and we have had recent hearings in the Governmental Affairs Committee pointing out how quickly the home-health care program has been abused by unscrupulous firms that form a number of different agencies, all providing a service as a front operation for a single individual with exaggerated costs.

What makes you so strongly in favor of this provision that would either have a Federal requirement, Federal qualification, or as generically defined in the bill—what assurance can we give to taxpayers in this case that it is not going to be abused without Federal requirement?

Mr. HACKING. First of all, with respect to the bill's definition of HMO's, we like the fact that it is broadened over what the Federal requirements are under title XIII. But as far as these other matters that you raised, fraud and abuse, and so on, I wonder if my colleague, Mr. Hagen, might have a few comments to make on those points.

Mr. HAGEN. I think that fraud and abuse, obviously have to be a concern to all of us, but I think a large concern on our part is the basic provisions of the generic qualifications in there for a competi-

tive health plan are close and parallel to the title 13. The access is very important, being able to be close enough to a health maintenance organization, to have it be a realistic option for their health care needs.

If, in fact, we make these requirements so restrictive, and so circumscribed, either through broader benefit packages or other means—in essence we may be providing less than full or adequate incentives for HMO's to offer medicare beneficiaries this option, and in effect cutting off our nose to spite our face.

So we would like to see——

Senator COHEN. Are you saying the potential benefits outweigh the risks?

Mr. HAGEN. That is what I am saying. The medicaid experience in California in the early 1970's, where medicaid eligibles were massively enrolled in HMO's is very instructive in this regard. Yes, from our point of view, the benefits from increased access do outweigh the risks; though we do feel that adequate safeguards are present within S. 1508.

Senator HEINZ. Gentlemen, do you have any further comments?

Mr. CLAYMAN. Just one final one.

Lest it be believed that I have grown soft in my older years, I want you to know that many of us have never lost our dream of a comprehensive health program of a national nature.

Senator HEINZ. Thank you very much.

Mr. HACKING. Mr. Chairman, coming back to your original question about what would happen if the plowback provision were not included in the bill, one point does come to mind.

If you have a health maintenance organization that has been expanding its services to enrollees, I should think that by and large that would be a result of competition—competition in a particular marketplace from other HMO's. But that is quite different from the situation where you have one HMO in a particular service area. There would be no competition from other HMO's.

Without the plowback that single HMO would be much less likely to expand benefits and services available. This is one reason why this provision should be included.

Senator HEINZ. Thank you, Mr. Hacking, and Mr. Clayman. Thank you both very, very much.

Our next witnesses are Dr. James F. Reynolds and Dr. Jay Rosan.

The Chair is pleased to note that Dr. Rosan is the associate medical director of HMO of Pennsylvania, and is from Fort Washington, Pa.

He is a very valued constituent.

Dr. Reynolds, would you begin?

STATEMENT OF DR. JAMES F. REYNOLDS, ST. LOUIS PARK MEDICAL CENTER, MINNEAPOLIS, MINN.

Dr. REYNOLDS. Senator Heinz and Senator Cohen, first let me express my gratitude to you for the privilege of appearing here.

My name is James Reynolds. I am a specialist in internal medicine at the St. Louis Park Medical Center, a 140-physician primarily fee-for-service multispecialty clinic in southwest Minneapolis.

Since 1972, we have sponsored the med center health plan, an HMO organization offering prepaid health care to employee groups and this has a current enrollment of over 80,000 people.

Appearing on different panels today are representatives of three other HMO's from the Fallon Clinic, Worcester, Mass., the Marshfield Clinic, Marshfield, Wis., and the Kaiser Health Plan in Portland, Oreg. Our four organizations as well as three other Twin City HMO's, including the SHARE group represented today by a beneficiary member, have recently become involved in the medicare demonstration project.

I will not elaborate on the inner workings of the HMO concept because I think that has been well covered.

It is premature to report on our enrollment experience, but the 10-month planning process has had a major impact on our sensitivity and understanding of health care management in this area. We have experienced an evolving, systematized organization of care that will address the unique needs of the elderly. Whether it be the technical skill of the surgeon's knife or the problem-solving skills of the diagnostician, our professional expertise will be no less effective than in the past. We feel that our multispecialty clinic posture has given good care in the 30 years we have been in existence and we expect that to continue.

However, the added task for true success in the complex areas of health care for the elderly also requires matching the problem with the appropriate solution and using widely the limited resources that society allows and provides. A "wellness promotion" philosophy permeates the planning process, superseding a simple "response to illness" readiness.

Our approach has been characterized by the assemblage of a number of diverse entities, some of which I would like to enumerate.

No. 1, a physically identifiable senior health service was created as the coordinating unit. It will be the initial point of entry for care of new patients, as well as a central focus for emergency and walk-in services. Coordination and triage function, and implementation and review of nursing home- and health-care services, will also be provided in this setting. The staff consists of primary care physicians in family practice and internal medicine, as well as geriatric nurse practitioners and support personnel. A social worker has been hired specifically to serve this area.

No. 2, realities impelled the development and better understanding of institutional alternatives and anticipated greater use of home-care services. Contractural arrangements were sought to assure ready availability of nursing home beds where needed. The very difficult problem of establishing criteria separating custodial from restorative and rehabilitative services was addressed.

No. 3, an intensive orientation program is underway inviting each enrollee to an introductory program addressing an understanding of how to use the system intelligently. It is hoped that some of the confusion will be diminished, and the results thus far have been pleasing.

No. 4, a hospital discharge planning process has been designed, which is felt to be key to maintaining appropriateness of hospital-

ization. Posthospital care needs assessment will begin within 24 hours of admission, and a methodology has been established.

No. 5, quality assurance assessment of our experiences by an internal audit mechanism has been unique to our overall operation for years, and has been extended to the demonstration project.

It is essential, we feel, to insure and evaluate the quality of care we are providing under any circumstances with professional excellence being our goal whether in the fee-for-service or prepayment sector.

And No. 6, similarly, our established education programs, such as diabetic care, hypertension screening and care, coping with stress, and so on, will be available through this program. New programs designed to meet the special needs of the elderly are being developed.

In conclusion, we will never be the same by reason of our decision, whether the project thrives or fails. We have been agitated and motivated to action toward a more intelligent use of our resources, and in the final analysis this can only translate to more efficient, cost-effective care, without compromise of quality. This program has been a catalyst for us to modify ourselves toward the evolving discipline of geriatric care. We would predict a similar stimulus to other organized provider groups if medicare reimbursement by the prepayment mode was given more universal enablement.

Thank you, Mr. Chairman.

Senator HEINZ. Dr. Reynolds, thank you.

[Testimony resumes on page 51.]

[The prepared statement of Dr. Reynolds follows:]

STATEMENT OF JAMES F. REYNOLDS, M.D., DEPARTMENT OF INTERNAL MEDICINE, ST. LOUIS PARK MEDICAL CENTER, MINNEAPOLIS, MINN.

I. Description of the Twin Cities' Experience

The Medicare demonstration project in the Twin Cities was originally designed to test a prospective capitation payment arrangement between Medicare and a number of health maintenance organizations in the Twin Cities. The contract to develop the program was signed in September, 1978, between the Health Care Financing Administration and six local HMOs.

The reimbursement method selected for this particular demonstration pays each HMO a fixed monthly fee equal to 95% of the AAPCC for each Medicare beneficiary joining that particular HMO. By basing the premiums on some percentage of Medicare's known cost, as opposed to the HMOs' costs anticipated to service the population (the adjusted community rate approach), the Twin Cities experiment allows the HMOs to convert any operating efficiencies into additional benefits to attract more Medicare beneficiaries. In a highly competitive health care environment like the Twin Cities, such a payment arrangement serves to increase the competition, making the Twin Cities an excellent "laboratory" to examine the impact of government policies on the evolution of competition in the nation's health care system.

The developmental phase of the contract proved to be a tortuous negotiation process between the HMOs and the government. As with most negotiations, this resulted mainly from a lack of understanding on the part of the HMOs as to the policies and administrative inflexibilities under which the government operates, and a lack of understanding by the government of the extent of the HMOs' concerns about the risks associated with a high utilizing population with which they had very little experience. As a result of these misunderstandings and inflexibilities, two of the HMOs dropped out of the experiment before it became operational, while the remaining parties were forced to accept compromises which ordinarily would not be acceptable in order to operate the demonstration.

In general, the problems we encountered with the government stem from an inability to negotiate to a final decision with any single government representative or department; a certain ingrained bias, perhaps based on Medicare's cost contract experience, about the way HMOs should operate, and a significant degree of inflexibility within existing Medicare administrative systems which requires HMOs to adopt procedures not normally required under a prospective capitation arrangement.

Experience to date under the demonstration is preliminary at best. Although we have been technically operational since last September, the HMOs were not really marketing or actively soliciting enrollment until April. There are currently just

over 6,000 members enrolled in the four HMOs, half of whom were enrolled in one of the HMOs under a prior cost contract with the government.

Enrollment has not met our expectations, but we foresee substantial improvements in the future as we become more acclimated to the market and its demands. We expect that by the end of the demonstration project all four HMOs will have sizeable Medicare populations enrolled: We'll offer very attractive benefit packages and will, hopefully, be operating on a sound financial basis. In terms of whether this particular way of reimbursing HMOs is efficacious, we totally support it. We believe that within a competitive health care environment it is an excellent way to allow all parties to the contract (i.e., the federal government, the Medicare beneficiaries, and the HMOs) to be properly rewarded for their efforts.

II. MedCenter Health Plan Background and Experience

A. MedCenter Health Plan is a non-federally qualified group practice model HMO that was developed and sponsored by the St. Louis Park Medical Center. The St. Louis Park Medical Center took a lead role in prepayment in Minneapolis-St. Paul by integrating a mix of prepaid medical care into its existing fee-for-service multispecialty practice. Since MedCenter began operations in 1972, we have grown to over 82,000 members and currently have enrolled 17.4 percent of the over 471,000 Twin Cities residents receiving health care services through one of seven HMOs in the metropolitan area.

In addition to its contract with the St. Louis Park Medical Center, MedCenter also contracts with three other groups of physicians and four hospitals in the metropolitan area. There are a total of 24 primary care locations where members can choose to receive their care.

Over the past eight years, our prepaid experience within existing group practices has shown that with the proper incentives of prepayment, physicians can respond with a cost-effective delivery of high quality health care services. We would also like to emphasize that we believe it is the method of practice (group practice) that creates the cost-efficiencies.

B. MedCenter Health Plan in 1978 began investigating the opportunities for developing an alternative approach for

Medicare reimbursement in an HMO model. Working with InterStudy and several of the other Twin Cities HMOs, our interest was to prove that if given the opportunity to contract with the government in the same manner that the HMO contracts with existing employer groups we could put into effect a wider range of benefits at a better price. MedCenter was interested in expanding the benefits of prepaid care to the Medicare-eligible population. However, we did not wish to seek the necessary Federal qualification to deliver care to this particular population. Federal qualification offers no advantages to MedCenter Health Plan in the Twin Cities marketplace. Federal qualification for MedCenter would only increase administrative costs through additional reporting requirements.

C. Our intention in the original response to a HCFA Medicare alternative reimbursement request for proposal was to offer at least a Medicare level of benefits through a contract with the government that would provide incentives for more cost-effective care. Early discussions with HCFA officials indicated that waivers on existing Medicare regulations could be obtained so that we could contract with the government in the same manner as we contract with our private sector clients. We were also given assurances that HCFA's administrative systems were capable of managing such a demonstration.

Since 1978 our experience with the development and the administration of the Medicare Demonstration Project has shown that on numerous occasions HCFA had difficulty in operating outside of existing rules and regulations. Throughout the developmental phase our negotiations found us having to agree to more regulations that HCFA could not waive. Many of these regulations have added to the operating expenses of administering this program. In many cases the regulations tend to negate our cost-efficiencies and increase our risk under our full risk contract.

D. Under the terms of our contract, we receive 95 percent of the average area per capita cost (AAPCC). In turn we assume full risk for the delivery of services. There are no retroactive community rating adjustments under the terms of our contract. The AAPCC represents the costs that Medicare reimburses to providers in the area. This does not represent the actual physician charges. It is estimated that only 50 to 60 percent of the physicians in our area accept Medicare reimbursement levels as payment in

full. Therefore the AAPCC does not fully represent the actual costs of medical care being delivered to the Medicare population.

It was very important to us to obtain utilization data and the AAPCC rates from HCFA early in the development phase to permit our actuaries to assist us in developing our benefit package and rates. There were numerous lengthy delays in receiving utilization data and AAPCC rates that severely hampered developing this project on a timely schedule. Even after receiving utilization data and rates, corrections had to be made by HCFA because of errors in constructing the data.

Another concern on our part was that the AAPCC does not accurately reflect the actual level of risk of the population. The AAPCC is only based on a mix of demographic variables that include age, sex, county, and categories of aged, disabled, welfare, and institutionalized. With the AAPCC rate cell approach, a rate is established for each demographic cell.

If an average cross section of eligibles enroll based on the demographic characteristics, the composite level of the AAPCC capitation may not reflect the actual costs of care when health status is considered. In other words, the severity of illness is not factored into the capitation figures. This concern becomes even greater when smaller numbers of individuals enroll. This risk to the HMO is greatly increased.

Throughout our developmental discussions there was little room to negotiate with HCFA. In determining the low option benefit premium rate, the monthly actuarial equivalent of deductibles and coinsurance was calculated by HCFA. HCFA's calculated figure was established as a limit, and no HMO could exceed it. This method did not recognize variations in costs across HMOs and tended to eliminate competitive pricing forces.

E. It is important to understand the risk that is being assumed by MedCenter Health Plan providers. Again under our contract with HCFA we assume full risk for the care of the individuals who enroll. In developing the premium rates and benefits for our Low Option and High Option plans, assumptions were required for the expected mix of members who might enroll based on the demographics used for the AAPCC. Therefore, it is important that marketing efforts be directed to attract the appropriate cross section of individuals.

To help offset the risk of anti-selection, anyone applying for our High Option benefit plan must complete and pass a medical questionnaire screening procedure. The High Option is available twelve months per year and provides members with all Medicare benefits plus the following:

- Routine physical, hearing, and vision examinations.
- Preventive immunizations.
- Prescription drugs with a $3.50 copayment per prescription.
- Expanded hospital and skilled nursing facility coverage to 365 days per benefit period.
- All Medicare deductibles and coinsurance are covered.

Our Low Option plan is available 30 days per year and open to all eligible applicants who apply. No health screening is required. The Low Option equates more closely to the current level of Medicare benefits but still offers the advantage that deductibles and coinsurance are fully covered.

The Board of Trustees of the St. Louis Park Medical Center was originally reluctant to become involved in the Demonstration Project. The concern on the part of the Trustees was based on the result of an internal study that revealed that 50 percent of the patients sampled over age 65 who were using the Medical Center were being treated for cancer. It was apparent that the multispecialty group practice was attracting a great deal of secondary care for the over 65 population. Thus, there was concern that the prepaid Medicare program would enroll a large number of current patients at the St. Louis Park Medical Center.

F. There were several problems encountered throughout the development of the project that delayed the operational phase. A major obstacle was that HCFA required that their master-file records be updated for all Part A claims. This necessitates that claims be adjudicated and filed by each HMO in the same manner that they are processed under the current Medicare program. This procedure is in direct conflict with the manner in which we administer our prepaid programs and thus only adds to the time and costs necessary to administer this program.

There were several instances during the developmental phase when HCFA positions or policies shifted or were re-interpreted.

It became very difficult to discuss or negotiate any of the key issues because the HMOs were never exposed to the decision-makers. We were given the feeling at numerous times that there was no opportunity for negotiating.

G. It is apparent that problems exist in HCFA's management information system as seen both in the developmental phase and in the current operational phase. It seems that many of the problems are due to HCFA attempting to administer a prospective prepaid contract on a system that was designed for retrospective reimbursement.

To cite an example, as the system exists we are required to send enrollment information to HCFA when an applicant has been approved for membership so that HCFA masterfile records can be adjusted. We are only able to process this information once a month. Responses from HCFA have been running two or more weeks late. Both of these factors create unnecessarily long delays in notifying applicants of their effective dates of coverage. This creates concerns and skepticism in the minds of the applicants.

H. We have currently enrolled approximately 600 members in our MedCenter Health Plan Senior Health Assurance Program since marketing efforts began in April. Our response has been less than anticipated as a result of confusion and an abundance of information provided to the senior citizens in the Twin Cities. We are aware that our marketing efforts need to incorporate more education and more one-on-one contact with prospective individuals. Our marketing strategies are being modified to allow for a more effective approach that exposes a larger portion of the Senior citizen population to the benefits that our prepaid program has to offer.

I. We do want to point out that we are committed to this program, and we are doing everything in our power to make it work effectively. A demonstration such as this cannot be expected to develop without a host of problems. We recognize that the officials at HCFA are carrying out their regulatory functions, and conflicts and discrepencies will always exist.

Of deepest concern to us is that the Demonstration is successful and that we can move towards enacting enabling legislation such as the Champ Act of 1981 introduced by Senator Heintz that will permit these Demonstration Projects to become a standard of practice.

Our overriding request is that we be heard by those responsible for amending current statutes and also be heard by those officials responsible for regulating this program or future programs. As the government moves toward deregulation, increasing competition and shifting responsibility to the private sector, it is essential for us to discuss and describe our experience in the private sector as providers of health care services. If we, as providers of health care services to the senior citizens, are given the responsibility to provide health care on a prepaid basis, free of unnecessary regulatory requirements, we will be able to improve the level of services available to the elderly and contain the costs of that care.

III. St. Louis Park Medical Center's Experience

It is premature to report on our experience, but the ten-month planning process has had a major impact on our sensitivity and understanding of health care management in this area. We have experienced an evolving, systematized organization of care that will address the unique needs of the elderly. Whether it be the technical skill of the surgeon's knife or the problem-solving skills of the diagnostician, our professional expertise will be no less effective than in the past, but the added task for true success requires matching the problem with the appropriate solution. A "wellness promotion" philosophy permeates the planning process, superseding a simple "response to illness" readiness.

Our approach has been characterized by the assemblage of a number of diverse entities:

A. A physically identifiable SENIOR HEALTH SERVICE was created as the coordinating unit. It will be the initial point of entry for care of new patients, as well as a central focus for emergency and walk-in services. Coordination and triage function and implementation and review of nursing home and health care services will also be provided in this setting. The staff consists of primary care physicians in Family Practice and Internal Medicine, as well as geriatric nurse practitioners and support personnel. A social worker has been hired specifically to serve this area.

B. Realities impelled the development and better understanding of institutional alternatives and anticipated greater use of home care services. Contractural arrange-

ments were sought to assure ready availability of nursing home beds where needed. The very difficult problem of establishing criteria separating custodial from restorative and rehabilitative services was addressed.

C. An intensive orientation program is under way inviting each enrollee to an introductory program addressing an understanding of how to use the system intelligently. It is hoped that some of the confusion will be diminished, and the results thus far have been pleasing.

D. A hospital discharge planning process has been designed, which is felt to be key to maintaining appropriateness of hospitalization. Post-hospital care needs assessment will begin within 24 hours of admission, and a methodology has been established.

E. Quality Assurance assessment of our experiences by an internal audit mechanism has been unique to our overall operation for years and has been extended to the demonstration project.

F. Similarly, our established education programs, such as diabetic care, hypertension screening and care, coping with stress, etc., will be available through this program. New programs designed to meet the special needs of the elderly are being developed.

In conclusion, we will never be the same by reason of our decision, whether the project thrives or fails. We have been agitated and motivated to action towards a more intelligent use of our resources, and in the final analysis this can only translate to more efficient, cost effective care without compromise of quality.

Senator HEINZ. Dr. Rosan, let me warn you. We may be interrupted. We have a vote on. We will have to adjourn in 4 or 5 minutes.

STATEMENT OF DR. JAY ROSAN, ASSOCIATE MEDICAL DIRECTOR, HEALTH MAINTENANCE ORGANIZATION OF PENNSYLVANIA, WILLOW GROVE, PA.

Dr. ROSAN. I am Dr. Jay Rosan, a family physician in practice in suburban Philadelphia. I practice with 2 other physicians and our group serves some 10,000 patients. Of those 10,000 patients, 1,800 are members of the Health Maintenance Organization of Pennsylvania. I also serve as an associate medical director of the HMO of Pennsylvania, which is based in Willow Grove. The HMO-PA currently serves 77,000 members in the Philadelphia metropolitan area and it is one of the most successful IPA model health maintenance organizations in the East.

The HMO of Pennsylvania has a long successful history with the general concept of direct capitation to physicians. I believe that paying physicians a fixed rate to provide care for their patients introduces strong incentives for the physician to insure that quality care is provided while avoiding overutilization of scarce medical resources. Under the fee-for-service system the patient must secure needed services on his or her own and insure that payment is available from some source. This is especially true since many physicians no longer accept assignment. With capitation, payment is made in advance, and the physician accepts the responsibility for both the medical and financial aspects of the patient's health care.

HMO-PA currently serves approximately 800 medicare patients. I receive a fair capitated fee adjusted according to age for each of my HMO-PA patients. It is then up to me to provide all the care which my patients need. The amount of paperwork which I must complete is significantly reduced for my HMO patients as compared with my fee-for-service patients.

In addition to the reduction of paperwork for my staff and I, it is of considerable benefit to the patient to reduce the complexity of the claims process. With the current medicare system, the amount of paperwork which the elderly must file becomes confusing and frightening. It becomes an additional barrier to overcome when they are sick and must secure health care. A patient that comes to see me through HMO has no forms whatsoever to fill out. I can see a patient as often as necessary without the patient becoming involved in any reporting mechanisms or any of the distress that often accompanies the claims-filing process.

I am concerned with the current medicare system which allows a patient to see one physician in the morning, another in the afternoon, and another in the evening, for the same disorder. This is unsettling for several reasons:

One, there is no continuity of care for the patient.

Two, incompatible, multiple drugs could be prescribed which might harm the patient.

Three, undue stress might be imposed on the person due to conflicting medical opinions.

Four, multiple physician contacts might eventually encourage multiple specialty referral, thereby compounding the above problem.

Five, the entire process is simply cost ineffective.

This describes a freeflowing system which is directed, not by a medically trained person, but by a sick individual who is not at all familiar with the complexity of the medical world of 1981.

Let's take the same fee-for-service medicare patient who has seen multiple physicians and finally winds up in a specialist's office. In many instances, this patient will be placed in a hospital to work up his or her illness. This is due to the fact that the specialist is unfamiliar with the patient and his medical history, and that it is easier, logistically, for the specialist to work up the patient in the hospital. The specialist has no financial incentive to discharge the patient at an early date. Instead, he or she has an incentive to keep the patient in the hospital because payment is made on a daily visit basis.

In the HMO system, the patient would see the primary physician who would make every attempt to work up the patient on an outpatient basis. Then, if a specialist would be needed, the patient, with tests in hand, would be referred by the primary physician. If the patient needed hospitalization, the primary physician would have the patient admitted on the primary's service and call in the specialist. Together, they would coordinate care and get the patient out of the hospital as soon as is medically appropriate. This is especially true because the primary is not paid any more to see the patient in the hospital. His or her incentive is to get the patient out of the hospital, thereby saving the largest number of dollars of the medical care delivery system. This process is clearly more cost effective and the quality of this carefully coordinated care is sound.

It is important to note that the medicare HMO member does not have to pay any copayments or deductibles. Also, office visits are covered in full for allowable services. This significantly reduces the amount of out-of-pocket costs that the patient may have, as was discussed earlier.

We support the legislation sponsored by Senator Heinz because we would like very much to see HMO coverage for medicare expand much more quickly than it has to date.

The current legislation, which prohibits payment to the HMO on a capitated basis, is the largest barrier to this growth. At present, medicare reimburses HMO-PA retrospectively, based on fee-for-service equivalents. If the HMO could be paid a capitation for the members, the administration of the program would be greatly facilitated and identical to our normal HMO plan. More medicare individuals, then, would begin to enjoy the benefits of HMO coverage.

In closing, I would like to emphasize the following five points regarding the provision of services in a capitation system:

One, the patient receives his or her health care in an organized, efficient manner, and enjoys the benefits of having his or her care carefully coordinated by a primary physician. In our system, there are 110 primary offices throughout the Delaware Valley.

Two, the physician is given an incentive to insure that the treatments given are medically necessary and appropriate.

Three, the paperwork requirements for both the patient and physician are significantly reduced, allowing for greater ease of access to medical care.

Four, the amount of out-of-pocket costs are significantly reduced to the patient.

Five, our system encourages, with a financial incentive, the use of outpatient services versus inhospital care when possible.

Medical care delivery in the eighties will face many challenges. What will be needed in the future is innovative efforts to reorganize the health care delivery system. It will take a joint effort among physicians, hospitals, government, and private industry. Capitation payment holds great potential for it allows physicians to do their jobs in an efficient manner while simultaneously providing a mechanism by which the fragmentation of medical care can begin to be rectified. Capitation is certainly not a panacea but it is an excellent first step. I can testify, as a physician working under both a successful capitation system and a fee-for-service system, that capitation does indeed work and it is effective.

Senator HEINZ. Thank you very much, Dr. Rosan.

[The prepared statement of Dr. Rosan follows:]

Jay R. Rosan, D.O. Testimony for CHAMP legislation. Washington, D.C. July 29, 1981

Good afternoon Senators. I am Dr. Jay Rosan, a family physician in practice in suburban Philadelphia. I practice with two other physicians and our group serves some 10,000 patients. Of those 10,000 patients, 1,800 are members of The Health Maintenance Organization of Pennsylvania. I also serve as an Associate Medical Director of The HMO of Pennsylvania which is based in Willow Grove. The HMO.PA currently serves some 77,000 members in the Philadelphia metropolitan area and it is one of the most successful IPA model health maintenance organizations in the East.

The HMO of Pennsylvania has a long successful history with the general concept of direct capitation to physicians. I believe that paying physicians a fixed rate to provide care for their patients introduces strong incentives for the physician to ensure that quality care is provided while avoiding over-utilization of scarce medical resources. Under the fee-for-service system the patient must secure needed services on his or her own and ensure that payment is available from some source. This is especially true since many physicians no longer accept assignment. With capitation, payment is made in advance and the physician accepts the responsibility for both the medical and financial aspects of the patient's health care.

HMO.PA currently serves approximately 800 Medicare patients. I receive a fair capitated fee adjusted according to age for each of my HMO.PA patients. It is then up to me to provide all the care which my patients need. The amount of paper work which I must complete is significantly reduced for my HMO Medicare patients as compared with my fee-for-service Medicare patients.

In addition to the reduction of paper work for my staff and I, it is of considerable benefit to the patient to reduce the complexity of the claims process. With the current Medicare system, the amount of paper work which the elderly must file becomes confusing and frightening. It becomes an additional barrier to overcome when they are sick and must secure health care. A patient that comes to see me through HMO has no forms whatsoever to fill out. I can see a patient as often as necessary without the patient becoming involved in any reporting mechanisms or any of the distress that often accompanies the claims filing process.

I am concerned with the current Medicare system which allows a patient to see one physician in the morning, another in the afternoon and another in the evening for the same disorder. This is unsettling for several reasons:

1. There is no continuity of care for the patient
2. Incompatible, multiple drugs could be prescribed which might harm the patient.
3. Undue stress might be imposed on the person due to conflicting medical opinions.
4. Multiple physician contacts might eventually encourage multiple specialty referral, thereby compounding the above problem.
5. The entire process is simply cost ineffective.

Obviously, the current system leaves much to be desired. It is a free flowing system which is directed, not by a medically trained person, but by a sick individual who is not at all familiar with the complexity of the medical world of 1981.

Let's take the same fee-for-service Medicare patient who has seen multiple physicians and finally winds up in a specialist's office. In many instances, this patient will be placed in a hospital to work up his or her illness. This is due to the fact that the specialist is unfamiliar with the patient and his medical history and that it is easier, logistically, for the specialist to work up the patient in the hospital. The specialist has no financial incentive to discharge the patient at an early date. Instead, he or she has an incentive to keep the patient in the hospital because payment is made on a daily visit basis.

In the HMO system, the patient would see the primary physician who would make every attempt to work up the patient on an out-patient basis. Then, if a specialist should be needed, the patient, with tests in hand, would be referred by the primary physician. If the patient needed hospitalization, the primary physician would have the patient admitted on the primary's service and call in the specialist. Together they would coordinate care and get the patient out of the hospital as soon as is medically appropriate. This is especially true because the primary is not paid any more to see the patient in the hospital. His or her incentive is to get the patient out of the hospital, thereby saving the largest number of dollars of the medical care delivery system. This process is clearly more cost-effective and the quality of this carefully coordinated care is sound.

I am very pleased with the way in which I can follow my patient's progress in a capitated system. I carefully track the care given and ensure that it is appropriate in my best medical judgment. As such I am very careful to ascertain that the treatments performed are necessary and beneficial to the patient. This is how our system is currently working.

In capitation there is a clear incentive for me to monitor the care being provided at all levels of the medical delivery system. The patient, of course is entitled to a second opinion in our system. The attention to the continuity of care issue becomes an integral part of the reimbursement system in a capitated health care organization.

I believe very strongly in capitation for it gives the physician a chance to practice his or her profession efficiently and effectively. It also provides the patient with a comprehensive set of benefits which are provided through an organized delivery system.

It is important to note that the Medicare HMO member does not have to pay any co-payments or deductibles. Also, office visits are covered in full for allowable services. This significantly reduces the amount of out-of-pocket costs that the patient may have.

We support the legislation sponsored by Senator Heinz because we would like very much to see HMO coverage for Medicare expand much more quickly than it has to date. The current legislation which prohibits payment to the HMO on a capitated basis is the largest barrier to this growth. At present, Medicare reimburses HMO.PA based on fee-for-service equivalents. If the HMO could be paid a capitation for the members, the administration of the program would be greatly facilitated and identical to our normal HMO plan. More Medicare individuals, then, could begin to enjoy the benefits of HMO coverage. Additionally, the Medicare system could more easily budget its operations by knowing that a fixed amount is to be paid for a given segment of the Medicare population. A cap on medical payments which could be instituted under such a system could help ease the current financial pressures on the Medicare system.

In closing, I would like to emphasize the following 5 points regarding the provision of services in a capitation system:

1. The patient receives his or her health care in an organized, efficient manner and enjoys the benefits of having his or her care carefully coordinated by a primary physician.

2. The physician is given an incentiv. to ensure that the treatments given are medically necessary and appropriate.

3. The paperwork requirements for both the patient and physician are significantly reduced, allowing for greater ease of access to medical care.

4. The amount of out-of-pocket costs are significantly reduced to the patient.

5. Our system encourages, with a financial incentive, the use of out-patient services versus in-hospital care when possible.

Medical care delivery in the 80's will face many challenges. What will be needed in the future is innovative efforts to reorganize the health care delivery system. It will take a joint effort among physicians, hospitals, government and private industry. Capitation payment holds great potential for it allows physicians to do their jobs in an efficient manner while simultaneously providing a mechanism by which the fragmentation of medical care can begin to be rectified. Capitation is certainly not a panacea but it is an excellent first step. I can testify as a physician working under both a successful capitation system and a fee-for-service system that capitation does indeed work and it is effective.

I am happy to entertain any questions you may have and I would like to thank you for this opportunity to speak with you.

Senator HEINZ. Let me note that you have an example of the sort of bill which a medicare beneficiary routinely receives and, without objection, I would include it in the record at this point, and I have exactly the same question that the medicare beneficiary has written in their handwriting at the bottom of the page.

The question is, How much do I owe?

I am looking at this bill and, not yet being on medicare, I would like to know how much the medicare beneficiary does, indeed, owe?

[The bill referred to follows:]

XPLANATION of MEDICARE BENEFITS

FOR THE CLAIM RECEIVED ON 01-08-81

PENNSYLVANIA BLUE SHIELD
BOX 65 CAMP HILL, PA. 17011

BENEFICIARIES LIVING IN PENNSYLVANIA
CALL TOLL FREE 800-382-1274

Keep this Medicare claim notice for your records.
A Request for Payment form is enclosed for your use.

PATIENTS NAME
DATE
HEALTH INSURANCE CLAIM NUMBER
CONTROL NUMBER

▲ ALWAYS USE INFORMATION IN BOX WHEN WRITING ABOUT THIS CLAIM

COL 1 SERVICES WERE PROVIDED BY	COL 2 WHEN FROM MO	DAY	TO MO	DAY	COL 3 AMOUNT BILLED	COL 4 AMOUNT APPROVED	COL 5 EXPLANATION OF ANY DIFFERENCE BETWEEN COLUMNS 3 AND 4 MEDICARE DOES NOT PAY FOR:	PLACE	NO.
[illegible]	01	22	12	29	1700	1500	SEE ITEM > ON BACK	1	1

NON-ASSIGNED TOTALS ▶	1700	1500	MEDICARE PAID ▼
Amount payable at 80% after the annual deductible ▶		1500	
Amount applied toward the annual deductible ▶		000	
Balance payable at 80% ▶		1500	1200
Inpatient radiology and pathology physician services and certain laboratories paid in full ▶		000	00
TOTAL MEDICARE PAYMENT ▶			1200

BE SURE TO READ IMPORTANT INFORMATION ON THE BACK OF THIS NOTICE

YOU HAVE MET $ 60.00 OF YOUR DEDUCTIBLE FOR 19 80

PAID TO

REMARKS ▼

How much more do I owe?

THIS IS YOUR CHECK ▼

DETACH ON DASHED LINE ▼

Dr. ROSAN. Well, the medicare beneficiary in this situation would owe $5. The charge was $17, payment by medicare was $12, so they would pay $5.

Senator HEINZ. So $5 has been added somehow to this?

Dr. ROSAN. I brought this along; I did not include it as we were going along because I thought we were rushed.

Senator HEINZ. I am going to have to go and vote.

Senator Grassley of Iowa is here.

Chuck, if you would continue. I think Senator Cohen and I will both be back. We have a couple of questions for these witnesses, so if you do not have any questions, just temporarily recess the hearing.

You are now the chairman of the committee.

Senator GRASSLEY [presiding]. I wanted to advise you the next vote will be a 10-minute vote.

Senator HEINZ. Is it back-to-back vote?

Senator GRASSLEY. Yes.

I will probably be gone before you are back.

What I wanted to come for was to zero in on some points and maybe they are points you have touched on. But the cost savings that you see in HMO's or whether they provide no cost savings—but are we going to get more for our money, more quality care because of the emphasis on prevention?

Dr. REYNOLDS. I will field that question from our perspective, Senator.

We feel there would be some very real cost savings, primarily in the area of institutional care. We think that inappropriate use of hospitalization is one of the things we can address ourselves to. In fact, we are very worried about that. The range of experience in our community is something like 3,500 bed-days per 1,000 medicare patients per year. Our aim is to get it down to 2,500 bed-days per 1,000 enrollees.

We feel, first of all, we are already as a group, directing efforts in this regard, and I think we do have it below the community average, but we do not know exactly where it is at the present time. But it is perfectly obvious it cannot be done without a system—I cannot tell you how often it happens that we see a patient recovering from a fractured hip or heart attack. The time comes to discharge him or transfer the patient to a nursing home and the arrangements have not been made.

There is no nursing home available, no nursing home bed available to take them, or it may be a weekend. The nursing homes in our area will not accept patients on weekends. Translate that in that particular instance to a 3-day extra hospitalization, and you are talking about $1,000 or thereabouts.

Translate that to an annual experience and we are talking about $50,000 a year. That is not the only area, but we feel that is one area where cost savings can be achieved. We must understand the nature of all the various institutional alternatives and use them wisely. To expand the use of home-care services which are just coming into view now and develop them to the extent that we will be able to have ready access to them is another goal. If care is still necessary and can be given effectively at home with home-care

assistance, this is obviously a desirable alternative not only costwise, but because people cherish their independence at home.

I think there is a problem of educating our physicians, too. I think if the nursing home says they cannot take a patient on a Friday, it is all too easy to change your orders and say, "All right, Monday."

When we are at risk, we are going to be more directly concerned about that patient getting to a nursing home if that is the proper alternative.

Senator GRASSLEY. Do you want to comment?

Dr. ROSAN. I do not think there is much question that there would be saving. To the degree, that is hard to answer. I feel our HMO, outside of Philadelphia, is probably saving at least 20 percent in regards to hospital days and hospital days are the biggest component in the health care delivery system.

To the patient, there is going to be a tremendous savings, I feel, and this will be all turned back. But to tell you how much, it is very difficult to say.

Senator GRASSLEY. What are the main deterrents to people joining HMO's?

Dr. ROSAN. I think the main deterrents are they feel they have to lose their physician, so to speak. In a group model HMO, which is not the one I am involved with, they have to go to that clinic or that center, and their physician may not have been in that center, and I think that is one of the biggest drawbacks that most people talk about.

Also, that they do not have a free selection. In an IPA type of HMO where there are multiple offices throughout the service area, this becomes less of a problem, because there is a chance their physician may be on the staff of the HMO or if they do not like the one they choose, they can choose another one more easily.

Dr. REYNOLDS. I might just comment on an ancillary problem. We have marketed this program only very recently, since April. Our experience has been an enrollment of 600 to 700, less than anticipated. Our original anticipation was 3,000 patients by the end of this year.

We perceive that there is some confusion in the marketplace. Elderly patients are barraged with a number of different plan offerings, including nonmedicare demonstration project offerings in our community.

I think there is a natural skepticism on the part of patients about a new plan. I think many of them feel content with certain aspects of the medicare program, but yet they do not perceive the inefficiencies that exist in it.

I think the idea of patients not wanting to leave their own physicians to come to a large multispecialty group practice is another real element in our community, but that really heightens the aspect of competing services or competing HMO's within a community.

Our approach to that is going to be to establish a program that is not only going to look at their illness but try to expand a program that will insure their wellness. That is a rather vague and ill-defined entity. What we are really saying in the marketplace, we

are going to try to have such a visibly attractive and effective program that people will want to come to us.

On the other hand, the idea is shared in our community where five or six HMO's would likewise like to present themselves to be the best plan. I think this is one of the real benefits of competing HMO's within the same geographical area. Good care and cost-effectiveness are the competing elements that each must address for survival.

Senator GRASSLEY. Dr. Rosan, you spoke about the reluctance of people to leave the close relationship they have with their own private physicians to come into HMO's.

Is there any way of overcoming what might be referred to as the psychological reason for people not wanting to do this or is it just something that only time will take care of?

Dr. ROSAN. This is new——

Senator GRASSLEY. I guess I ought to phrase it, have there been any studies or approaches trying to overcome this?

Dr. ROSAN. I do not know because we looked into this, too. I think the problem is that somebody who is in the medicare age, they know medicare. They have their card in their hand. Here it is. They can go to whatever physician they like to. All of a sudden, we have someone come in with something called an HMO. Is this Black Cross? Is it cancer insurance? They do not understand it, and there is a fear of the unknown. As time goes on and more medicare-aged people have positive experiences in the HMO environment, I think we are going to have a change. But it will take time.

Dr. REYNOLDS. Senator, can I add to that?

I think the passage of the CHAMP Act will help eliminate some of that. Right now, the limited experiences of demonstration projects foster the confusion. If the Government were to come out and extend it universally, I think it would give it more visibility in a more universal way.

Senator GRASSLEY. Since no one else is here and I have no more questions, this vote was just concluded, so it should just be a matter of a minute or two until the second vote comes, and then I suppose Senator Heinz will be back here.

So I suppose we will take about a 10-minute recess.

[A brief recess was taken.]

Senator HEINZ [presiding]. Dr. Reynolds, Dr. Rosan, thank you for your patience. We could very well be interrupted again so I will keep my questions brief.

Both of you in your testimony indicate a number of features regarding the efficiency and effectiveness of the health maintenance organization system of health care delivery.

You mention the cutback in paperwork for the physician and for the patient. You mentioned a continuity of care, the incentive to save money with respect to outpatient versus hospital care, length of stays in hospitals, and so forth, and while these are goals that are very worthy, very noble, from the perspective of efficiency and quality of patient care, my question is, what personal incentives are offered in the health maintenance organization setting to encourage physician participation in those kinds of arrangements and those kinds of plans?

Why would a physician, a good physician, who can get hundreds of dollars at a shot, literally a figure in some cases, join up?

Dr. REYNOLDS. Senator, in our clinic setting, of course, we all practice as one unified group and the incentive is to give better care. We are all on a salaried basis budgeted yearly so actually there is no greater or lesser return to be expected by our experience, that is, the individual physician's experience. Our clinic is a multispecialty fee-for-service clinic, but in 1972 we did get into the HMO area. We felt that has real benefits to patients and that it would help us look at our own system and use our time more efficiently and we did do that.

Now, we are at the point where our friendly critics are saying, now that you have had good experience with the young, relatively healthy HMO population, let's do that with the patients or the population that has the real problems, the medicare group. That is the challenge we chose to meet and that is the type of approach we have.

Senator HEINZ. Let me ask this, though.

Do you think you could be making—you, yourself--more money or do you think that some of the doctors or maybe even all of the doctors who are full-time salaried physicians, could be making more money if they were out in a basic fee-for-service area?

Dr. REYNOLDS. There is no question.

Senator HEINZ. Then why are you in something that appears to be against your financial interest?

Dr. REYNOLDS. Those motives are addressed by most physicians joining a multispecialty clinic where you give up something of your independence for the sake of working with a group, and not only do we get involved with patient care, but there is a wide variety of involvement, such as a chance to teach, to do research, to do other things besides render care but which ultimately contribute to good care.

It really is not a compromise. It is being able to expand what we do and make life more interesting, an indulgence to our idealism. It is also not incompatible with a reasonable living standard.

Senator HEINZ. Dr. Rosan, what do you think?

Dr. ROSAN. Well, I think there are some physicians who are not geared for HMO's. The financial incentives are such that they will not join an HMO. But there are a good number of physicians that are aware nowadays that people are pretty important also, and if you do not have patients satisfied and happy, that you are not going to continue in practice. I think there are a lot of physicians who are a little idealistic in nature and see this as a situation that will work.

Sometimes a patient will come to me and I want to see the patient the next day. I am concerned, the patient has a 104° temperature and I might not have made the diagnosis—I do not know what the problem is. I am always worried that when I say come back tomorrow they will say you are just trying to make more dollars. With an HMO I do not have that worry. I can bring the patient back 5 days in a row. I think it offers the physician no billing problems. We are paid on a capitative basis. We get the checks on time and there is no problem in that regard.

I hear the buzzer again.

Senator HEINZ. Let me worry about it.

Dr. ROSAN. There are physicians who will not go to HMO's. But in our area, one of the factors is competition. Initially, there were physicians who joined who are idealistic and wanted a better system and now our HMO has 110 offices with 250 primary physicians throughout the Delaware Valley. They all join for different reasons, but now because there is such a wide number of physicians, competition plays a role. They are afraid of losing some of their patients. I am sure that does play a role.

Senator HEINZ. In your remarks, Dr. Rosan, you indicated sometimes there are patients who will go to different doctors you said, morning, noon, and night, under the fee-for-service system.

Is that really true? Does that really happen or is that just a figure of speech?

Dr. ROSAN. I exaggerated a little bit by saying in 1 day, but it does happen in 1 week. You send a patient to a cardiologist. They do not like the cardiologist because he parts his hair on the wrong side, or the cardiologist did not treat him right. They will have two different opinions in 1 week.

All of a sudden you get letters from these cardiologists.

Senator HEINZ. But they ask you something that seems quite fundamental. The key aspect of a capitation arrangement is the contract between physicians and insurers which is a feature that puts both at risk, but also provides both with a significant incentive to make the most prudent decisions about health care.

In this kind of delivery system where physicians have a greater stake in appropriate utilization, it seems to me that utilization review would be, in effect, an ongoing responsibility of physicians.

So, my question for you, Dr. Rosan, as one that practices both fee for service and in a capitation service, do you find a difference in utilization review processes?

Dr. ROSAN. You are darn right. There is no doubt about it. In the offices across the United States—there is very little looking at offices and physicians' practices. Whether someone has an EKG done on a patient every week, or every month, or once a year, these types of questions should be answered. We look at these things. We do look at utilization rates.

I think the biggest problem is underutilization. Overutilization will come up real quick but underutilization is the biggest worry. In our HMO particularly we do constant auditing of people. We send out outcome surveys to our patients. We are one of the few HMO's in the country doing this. We ask the patients what happened in their office visit, what was the diagnosis, were your laboratory results explained to you. Then we get the office visit chart and compare the two. To determine whether the physician took care of the patient's needs.

So underutilization is a concern and I think every good HMO is well aware of this and is doing something about it.

Senator HEINZ. Dr. Reynolds, do you have any comments?

Dr. REYNOLDS. We are primarily a fee-for-service group. About 60 percent of our work is in the fee for service and 40 percent in the HMO area. We have utilization review processes set in place. We also have a quality assurance group that has been operative for a number of years. One of the very special problems that we are

constantly looking at is to see that the same degree and brand of care is being given to the HMO recipient as to the fee-for-service recipient.

It would be very damaging to us if it turned out otherwise, if there was lesser care given.

Senator HEINZ. I will have to recess the hearing briefly.

I appreciate your patience, but we will recess temporarily so that the chairman and any other members can vote.

[A brief recess was taken.]

Senator HEINZ. The Chair welcomes our fourth panel, thanks the preceding witnesses, Dr. Reynolds and Dr. Rosan, for their understanding and patience, and welcomes Mr. Coe, Dr. Greenlick, Dr. Lewis, and Mr. O'Connell.

I have a note that the panel is going to give, correct me if this is wrong, one joint testimony to be presented by Mr. Coe, in order to allow more time for questions.

Thank you very much.

If any of you gentlemen violently disagree, please proceed to do so.

Mr. COE. We are all in agreement.

Senator HEINZ. Obviously, each of you does have a statement and we will, by unanimous consent, put those in the record in full.

STATEMENT OF GERALD L. COE, ACTING EXECUTIVE VICE PRESIDENT/CHIEF COUNSEL, GROUP HEALTH COOPERATIVE OF PUGET SOUND, SEATTLE, WASH.; ACCOMPANIED BY MERWYN R. GREENLICK, DIRECTOR, HEALTH SERVICES RESEARCH CENTER, KAISER FOUNDATION HEALTH PLAN, INC., PORTLAND, OREG., DR. RUSSELL F. LEWIS, MEDICAL DIRECTOR, GREATER MARSHFIELD COMMUNITY HEALTH PLAN, MARSHFIELD, WIS., AND JOHN P. O'CONNELL, EXECUTIVE DIRECTOR, FALLON COMMUNITY HEALTH PLAN, WORCESTER, MASS.

Mr. COE. Mr. Chairman and members of the committee, I am Gerald Coe, a member of the board of directors of the Group Health Association of America. GHAA represents a majority of the group and staff model health maintenance organizations in the Nation, over 100 plans, and our members serve approximately 8 million enrollees, 80 percent of the total national HMO enrollment.

I am also acting chief executive officer for Group Health Cooperative of Puget Sound, the only HMO with a risk-based medicare contract under present law.

With me today are representatives from three HMO's currently serving medicare members under contracts with HCFA for risk-basis demonstration projects. We would each like to submit written statements for the record.

Senator HEINZ. Without objection, that will be done.

Mr. COE. Today, there are over 240 HMO's serving nearly 10 million members nationwide. The competitive impact of HMO's on the markets in which they operate has been repeatedly demonstrated. Through a comprehensive, coordinated system of health care delivery, HMO's create incentives for the appropriate and efficient use of services while at the same time improving access to care. The impact of these internal incentives is most dramatically

evidenced in the rate of hospital utilization of HMO's which is one-third to one-half lower than comparable fee-for-service utilization. HMO's can usually provide a much broader range of services to their enrollees than is found in standard indemnity plans. By providing an alternative to the fee-for-service system, HMO's inject an element of competition into the marketplace which can alter the patterns of service delivery by other providers.

When the medicare program was enacted, it held out to older Americans the promise of access to adequate, affordable health care. Unfortunately, for too many beneficiaries, this promise has gone unfulfilled. Since 1965, inflation in medical costs has led to excessive out-of-pocket payments, added expenses. Restrictions on coverage and difficulties in convincing physicians to accept assignment have resulted in a failure of the program to deliver services at a cost and in a manner which Congress originally intended.

Health maintenance organizations can offer the elderly a measure of relief from some of these administrative and financial burdens and at the same time can offer the Federal Government a more efficient utilization of its medicare dollar.

Only 1.5 percent of medicare beneficiaries, or 350,000 out of 25 million, receive their health care through HMO's. Of 200 operating HMO's, only 47 have become medicare providers, and the main reason for their doing so has been to continue service to current enrollees after they have attained age 65.

The problem with current medicare reimbursement options for HMO's is that cost-based per capita reimbursement mechanisms under sections 1833 and 1876 both impose upon HMO's retrospective cost finding based upon the delivery of specific services. This methodology is suited to the fee-for-service system not the HMO's method of providing care for a prospectively determined premium and its budgeting and ratemaking process. The medicare beneficiary receives no benefit from savings generated by HMO efficiencies.

Risk-based reimbursement under section 1876 does place the HMO at risk but final payment remains retrospective and is sometimes delayed 2 or 3 years following the provision of services. The reimbursement mechanism does provide that the HMO and HHS share equally in the first 20 percent of the savings resulting from the difference between the HMO's cost for service to its medicare members and the comparable cost for delivery of services to those members in the fee-for-service sector in the area in which the HMO is located. Any further savings are returned to the Federal Government. While the HMO receives some of the benefit of its efficiencies, current law does not require that this benefit be used for the benefit of the HMO's medicare members as it properly should be.

A third problem with current law and a provision which is as much at odds with the HMO's method of operation as the long delayed payment, is the requirement that the HMO offer a benefit package limited to medicare mandated services. Such a package excludes preventive and health maintenance services which are an integral part of the HMO's comprehensive health care system, and a major advantage which the HMO offers its enrollees. HMO's

should be permitted to offer comprehensive benefit packages to their medicare members.

Finally, a serious drawback of section 1876 has been the requirement that all HMO medicare members, including those enrolled in the HMO at the time the plan enters into a risk-based contract, agree to receive all medicare covered services through the HMO. This imposes a significant hardship on the current medicare members who are accustomed to medicare reimbursement for out of plan services. A change in their habitual pattern of seeking health care would be traumatic, but under section 1876, the equally unattractive alternative is terminating membership in the HMO. There is need for a provision which would allow a reasonable transition to the new requirement.

S. 1509, the Competitive Health and Medical Plan Act, goes far in addressing the shortcomings of present law and with a few modifications we believe the measure will create a workable mechanism to increase the attractiveness of HMO membership to medicare beneficiaries.

We endorse the basic framework of this formula. It at last provides the HMO with a prospective fixed payment which places the plan at risk in the same manner it accepts risk for the provision of care to its nonmedicare members. If there are problems with the AAPCC as an accurate indicator, these can surely be defined and remedied in light of experience. In the meantime, all reimbursement in excess of the ACR must be returned to the medicare members. It is the beneficiary who gains through the savings which are generated.

The bill permits the savings to be returned to the beneficiary in the form of reduced copayments and deductibles, added benefits or cash rebates. We are very concerned about the option to provide cash rebates in all cases.

We believe that medicare funds should be used to directly increase and improve the delivery of services to the elderly population they are intended to benefit. This bill quite rightly permits the HMO to structure the use of these savings in the manner most suited to its particular medicare population and allows the HMO to offer a benefit package richer than medicare parts A and B services as its basic offering to medicare beneficiaries if doing so will not substantially discourage enrollment.

We support a provision such as that in S. 1509 which permits medicare beneficiaries who are members of the HMO at the time it enters into a risk-based contract to elect to continue to receive their care on a cost-basis. This provision recognizes that it is difficult for the elderly to alter habits of freely seeking care outside of the plan, a practice not allowed under the risk-basis arrangement.

We also support the open enrollment provision of this proposal. HMO's will be required to enroll medicare members during open enrollment periods designed to make the plan readily available to a representative cross-section of the eligible medicare population in the community.

Finally, we strongly urge that an HMO's option of electing to serve medicare members on a cost-basis under the current section 1876 be retained. It may be more appropriate for a plan, because of

its size or age or lack of sophistication or other valid reasons, to contract with HCFA on a cost-basis.

This bill is based on sound principles. It can afford medicare beneficiaries sorely needed benefits without unconscionable costs to them or to the Government. We are grateful, Mr. Chairman, for your sponsorship and would be happy to offer suggestions for the modifications we have discussed.

[Testimony resumes on page 100.]

[The prepared statements of Mr. Coe, Dr. Greenlick, Dr. Lewis, and Mr. O'Connell follow:]

STATEMENT OF GERALD L. COE, ACTING EXECUTIVE VICE PRESIDENT/CHIEF COUNSEL, GROUP HEALTH COOPERATIVE OF PUGET SOUND, SEATTLE, WASH.

Mr. Chairman and Members of the Committee, I am Gerald Coe, a member of the Board of Directors of the Group Health Association of America. GHAA represents a majority of the group and staff model health maintenance organizations in the nation, over 100 plans, and our members serve approximately 8 million enrollees, 80% of the total national HMO enrollment.

I am also Acting Chief Executive Officer for Group Health Cooperative of Puget Sound, the only HMO with a risk-based Medicare contract under present law.

With me today are representatives from three HMOs currently serving Medicare members under contracts with HCFA for risk-basis demonstration projects. We would each like to submit statements for the record.

When the Medicare program was enacted in 1965, the entire HMO industry consisted of only 10-12 plans, and little consideration was given to contracting with them on a prepaid basis in a manner consistent with their fiscal structure.

Today, there are over 240 HMOs serving nearly 10 million members nationwide. The competitive impact of HMOs on the markets in which they operate has been repeatedly demonstrated. Through a comprehensive, coordinated system of health care delivery, HMOs create incentives for the appropriate and efficient use of services while at the same time improving access to care. The impact of these internal incentives is most dramatically evidenced in the rate of hospital utilization of HMOs which is one-third to one-half lower than comparable fee-for-service utilization. The savings so generated are translated into benefits for our members, thus HMOs can usually provide a much broader range of

of services to their enrollees than is found in standard indemnity plans. By providing an alternative to the fee-for-service system, HMOs inject an element of competition into the marketplace which can alter the patterns of service delivery by other providers.

With the growth of the HMO industry and its establishment as an accepted and important part of the health care delivery system, the time has come to develop a method of Medicare reimbursement which takes advantage of all of the incentives and benefits of an HMO.

When the Medicare program was enacted, it held out to older Americans the promise of access to adequate, affordable health care. Unfortunately, for too many beneficiaries, this promise has gone unfulfilled. Since 1965, inflation in medical costs has led to excessive out-of-pocket payments, added expenses. Restrictions on coverage and difficulties in convincing physicians to accept assignment have resulted in a failure of the program to deliver services at a cost and in a manner which Congress originally intended.

Health maintenance organizations can offer the elderly a measure of relief from some of these administrative and financial burdens and at the same time can offer the federal government a more efficient utilization of its Medicare dollar.

Through an HMO, the Medicare beneficiary not only receives comprehensive services from a single source, including preventive care and any specialty care he or she might need, but also has the security of knowing that these services will be provided at a predictable prepayment. Since most older Americans live on fixed incomes, the certainty of a cap on health care costs is even more important to Medicare beneficiaries than to active wage earners.

There have been a number of reasons for low HMO Medicare enrollment to date including restrictive state laws and the opposition of established medical institutions which have inhibited HMO growth. However, the chief reason has been the Medicare reimbursement options available to HMOs.

Thus, only 1.5 percent of Medicare beneficiaries, or 350,000 out of 25 million, receive their health care through HMOs. Of 200 operating HMOs, only 47 have become Medicare providers, and the main reason for their doing so has been to continue service to current enrollees after they have attained age 65.

The problem with current Medicare reimbursement options for HMOs is that cost-based per capita reimbursement mechanisms under section 1833 and section 1876 both impose upon HMOs retrospective cost finding based upon the delivery of specific services. This methodology is suited to the fee-for-service system not the HMO's method of providing care for a prospectively determined premium and its budgeting and ratemaking process. The Medicare beneficiary receives no benefit from savings generated by HMO efficiencies.

Risk-based reimbursement under section 1876 does place the HMO at risk but final payment remains retrospective and is sometimes delayed two or three years following the provision of services. The reimbursement mechanism does provide that the HMO and HHS share equally in the first 20 percent of the savings resulting from the difference between the HMO's cost for service to its Medicare members and the comparable cost for delivery of services to those members in the fee-for-service sector in the area in which the HMO is located. Any further savings are returned to the federal government. While the HMO receives some of the benefit of its efficiencies, current law does not require that this benefit be used for the benefit

of the HMO's Medicare members as it properly should be.

A third problem with current law and a provision which is as much at odds with the HMO's method of operation as the long-delayed payment, is the requirement that the HMO offer a benefit package limited to Medicare mandated services. Such a package excludes preventive and health maintenance services which are an integral part of the HMO's comprehensive health care system, and a major advantage which the HMO offers its enrollees. HMOs should be permitted to offer comprehensive benefit packages to their Medicare members.

Finally, a serious drawback of section 1876 has been the requirement that all HMO Medicare members, including those enrolled in the HMO at the time the plan enters into a risk-based contract, agree to receive all Medicare covered services through the HMO. This imposes a significant hardship on the current Medicare members who are accustomed to Medicare reimbursement for out of plan services. A change in their habitual pattern of seeking health care would be traumatic, but under section 1876, the equally unattractive alternative is terminating membership in the HMO. There is need for a provision which would allow a reasonable transition to the new requirement.

S. 1509, the Competitive Health and Medical Plan Act, goes far in addressing the shortcomings of present law, and with a few modifications we believe the measure will create a workable mechanism to increase the availability of HMO membership to Medicare beneficiaries.

Under this bill and similar proposals, HCFA will calculate the average cost of providing Medicare services in the HMO's service area to a population similar in composition to the Medicare beneficiaries expected to enroll in the HMO, the adjusted average per capita cost or AAPCC.

The HMO will be paid, prospectively, 95% of this amount. Based upon information submitted by the HMO, HCFA will then calculate the HMO's adjusted community rate or ACR. With the HMO's premium for its non-Medicare members as a starting point, adjustments will be made to reflect the Medicare benefit package and a time and complexity factor appropriate to the added attention and care needed by elderly patients. Because the ACR is based upon the HMO's premium, the HMO receives a contribution to its capital retention, marketing and other appropriate costs which are attributable to the provision of services to its Medicare members. This means that with respect to its Medicare members, it recovers these costs in the same way that it does for its non-Medicare members. Any difference between the AAPCC and the ACR must be used for the benefit of the Medicare members.

We endorse the basic framework of this formula. It at last provides the HMO with a prospective fixed payment which places the plan at risk in the same manner it accepts risk for the provision of care to its non-Medicare members. If there are problems with the AAPCC as an accurate indicator, these can surely be defined and remedied in light of experience. In the meantime, all reimbursement in excess of the ACR must be returned to the Medicare members. It is the beneficiary who gains through the savings which are generated.

S. 1509 permits the savings to be returned to the beneficiary in the form of reduced copayments and deductibles, added benefits or cash rebates. We are very concerned about the option to provide cash rebates in all cases. HMOs are fundamentally providers of health care not dollars. An inherent characteristic of an HMO is prepayment, that is that health care is paid for when it is most affordable and not at the time of sickness or injury when it is least affordable. Cash rebates are, therefore, inconsistent with the way HMOs do business and frustrate the overall purpose of the legislation

to accommodate Medicare reimbursement to HMOs. If rebates are to be seriously considered, they should be designed specifically to meet special situations.

We believe that Medicare funds should be used to directly increase and improve the delivery of services to the elderly population they are intended to benefit. This bill quite rightly permits the HMO to structure the use of these savings in the manner most suited to its particular Medicare population and allows the HMO to offer a benefit package richer than Medicare Part A and Part B services as its basic offering to Medicare beneficiaries if doing so will not substantially discourage enrollment. This latter provision will permit the HMO to treat its Medicare and non-Medicare members alike by offering them similar comprehensive benefit packages. We are concerned about the requirement that a group of Medicare members shall select the added benefits provided through the use of the savings. Sound marketing principles demand that the benefits offered respond to the needs and preferences of the Medicare members. The HMO's normal policymaking process would be circumvented, and the potential benefit is far from certain.

We support a provision such as that in S. 1509 which permits Medicare beneficiaries who are members of the HMO at the time it enters into a risk-based contract to elect to continue to receive their care on a cost-basis. This provision recognizes that it is difficult for the elderly to alter habits of freely seeking care outside of the plan, a practice not allowed under the risk-basis arrangement.

We also support the open enrollment enrollment provision in S. 1509. HMOs will be required to enroll Medicare members during open enrollment periods designed to make the plan readily available to a representative cross-section of the eligible Medicare population in the community. In the process of attracting and enrolling Medicare

beneficiaries, HMOs develop marketing techniques which both reach the elderly and accurately inform them of the benefits and obligations of HMO membership. However, requiring the HMO to regularly provide information about the HMO to all Medicare eligibles in the area imposes a burden on the plans which they cannot realistically meet. We would be willing to cooperate with the staff to develop a workable provision.

S. 1509 requires that the contracting entities be federally qualified or state licensed HMOs or competitive medical plans meeting a somewhat broader definition with adequate safeguards for the Medicare members. We urge that plans falling within this last definition be required to offer preventive services in addition to physicians' services, inpatient hospital services, laboratory, x-ray and emergency services and out of area coverage. This will assure that all plans, HMO or non-HMO, will compete on an equal basis. It also assures that the full benefit of the system is available to the Medicare enrollees regardless of the plan they select.

Finally, we strongly urge that an HMO's option of electing to serve Medicare members on a cost-basis under the current section 1876 be retained. It may be more appropriate for a plan, because of its size or age or lack of sophistication or other valid reasons, to contract with HCFA on a cost-basis for the provision of Medicare Part A and Part B services.

S. 1509 is based on sound principles. It can afford Medicare beneficiaries sorely needed benefits without unconscionable costs to them or to the government. We are grateful, Mr. Chairman, for your sponsorship and would be happy to offer suggestions for the modifications we have discussed.

STATEMENT OF MERWYN R. GREENLICK, DIRECTOR, HEALTH SERVICES RESEARCH CENTER, KAISER FOUNDATION HEALTH PLAN, INC., PORTLAND, OREG.

Mr. Chairman and Members of the Committee: I am Merwyn R. Greenlick, Director of the Health Services Research Center of Kaiser Foundation Health Plan, Inc., of Portland, Oregon. I am also Director of the Medicare HMO demonstration in Portland, sponsored by the Health Care Financing Adminstration and Kaiser Permanente Medical Care Program.

Kaiser Foundation Health Plan, Kaiser Foundation Hospitals, and eight independent Permanente Medical Groups comprise the Kaiser-Permanente Medical Care Program. The Program is an economically self-sustaining, organized health care delivery system that provides health services on a prepaid, direct-service basis to over 3.9 million members in California, Colorado, the District of Columbia, Hawaii, Maryland, Ohio, Oregon, Texas, Virginia, and Washington. Kaiser-Permanente members receive services through 28 hospitals, 85 outpatient facilities, more than 4,200 full-time physicians and over 36,000 other employees.

The Kaiser-Permanente Program is the largest prepaid group practice program in the United States. The Program's membership includes more than 200,000 individuals who are Medicare beneficiaries. The vast majority of these individuals belonged to Kaiser Foundation Health Plan before they reached 65 and continued their membership by enrolling in the Program's Medicare supplemental plan.

The purpose of this statement is to discuss changes in the Medicare program that would create greater incentives for Medicare beneficiaries to seek HMO membership and to encourage HMOs to enroll more elderly citizens. Our views are based not simply on the importance we attach to incentives as a key to development of a more efficient health care delivery system, but on the experience of a Medicare demonstration project that Kaiser-Permanente is currently operating in Portland, Oregon. The project is one of five sponsored by the Health Care Financing Administration (HCFA) involving HMOs and the Medicare population.

There have been a number of prior efforts to change the way Medicare pays HMOs, but it is especially important that a satisfactory method of payment be adopted at this time. During the past eight years, federal policy toward HMOs has been mixed. Financial support has been provided under the HMO Act and pursuant to Section 1310 of the Act, millions of employees, mostly under the age of 65 have been offered membership in an HMO for the first time. On the other hand, the existing methods by which Medicare pays HMOs are inadequate. They do not provide incentives for HMOs to enroll members or for Medicare beneficiaries to join HMOs. As a result, the number of Medicare beneficiaries enrolled in HMOs is small, and most Medicare enrollees belonged to the HMO before they became eligible for Medicare.

The federal government will be terminating its financial support of HMOs. As it does so, we believe the adoption of a

satisfactory Medicare HMO payment provision is imperative so that HMOs will finally be able to obtain access to the largest health benefits program in the country.

Of more importance, is the fact that millions of Medicare beneficiaries have been effectively denied the opportunity to be members of HMOs. Such membership can be a meaningful benefit. HMOs are organized health care delivery systems that provide coordinated care. Their physicians are able to guide the elderly through the often confusing maze of specialists and services necessary for their care. HMO benefit plans are generally comprehensive with no deductibles and only nominal copayments so that total health care costs are predictable and financial catastrophe because of acute health care costs is virtually impossible. In addition, the large amount of paperwork that burdens most Medicare beneficiaries does not exist in HMOs.

Finally, the cost of an HMO for comparable benefits is generally less than the cost of fee-for-service care. This is largely attributable to appropriate hospital use. In the Portland demonstration, if hospitalization continues at current levels, it will represent less than 60% of the use rate of Medicare persons in community hospitals in Portland.

Despite these factors, only a small number of Medicare beneficiaries are members of HMOs. When Medicare was enacted in 1965, it did not contain any provision to pay group practice prepayment plans (one of the HMO prototyes) on a basis consistent

with the way they were paid for the non-Medicare members. Instead, hospitals which served group practice prepayment plan members were paid under Part A on the same basis as other hospitals and such plans were paid for Part B services on a per capita basis which was cost based. The only other option was to submit bills and be paid on a fee-for-service basis.

In 1972, Congress added Section 1876 to Title 18 of the Social Security Act. This section provided for an improved method of payment for HMOs. It provided for a capitation payment for both Part A and B services on either a cost or risk basis and established the important principle that an HMO that chooses a risk contract would receive a portion of the savings (the difference between the average cost in the area for fee-for-service Medicare beneficiaries with smiliar characteristics to the HMO's members and the HMO's costs for its Medicare members).

This provision contained a number of problems. First, the final payment to the HMO is made retrospectively and may not be determined and paid to the HMO until two or three years after services are provided. This requires an HMO to finance the use of the savings if it uses them to reduce the costs of, or add benefits for Medicare members, a risky and expensive provision. Second, Section 226(b) of P.L. 92-603 (the legislation which added Section 1876 to Title 18) provides that when an HMO enters into a risk agreement all its existing members must agree to obtain <u>all</u> their Medicare covered services through the HMO or terminate their membership. Under its general provisions, Medicare pays

for services received outside the HMO. Making this change in coverage would be traumatic for many older persons. This is the major reason our Program and other HMOs with large Medicare memberships have not entered into Section 1876 risk contracts. We believe that requiring long-standing Medicare members of an HMO to limit their sources of services, or no longer belong to the HMO is unreasonable. Third, Section 1876 requires an HMO to offer one benefit package that covers only Medicare services. This excludes preventive and health maintenance services. This requirement is alien to the concept of health maintenance organizations and makes no sense. Finally, there is no requirement in Section 1876 about how HMO savings are to be used. Thus, HMOs need not pass on the savings to their members in the form of added benefits or reduced premiums.

The present Medicare payment proposal resolves those problems. Payments would be determined prospectively with no retrospective adjustments. An HMO would know in advance how much it would receive, could plan accordingly and would not have to finance the "savings." Existing Medicare members of an HMO would have the option of changing to the new program or remaining under the old one. It is important to note that in our Portland demonstration, when this option was offered to 9,000 existing Medicare members, only 3,000 of them applied for the new program. HMOs would be required to pass their savings on to their members. This is an important requirement

to assure that Medicare beneficiaries receive full benefits and to provide maximum incentives for them to join the HMO. Finally, an HMO would be able to develop benefit plans which covered preventive and health maintenance services and would not be required to offer a Medicare only benefit plan.

The proposal contains two new concepts: prospective average per capita costs and the adjusted community rate. These are necessary in order to determine the amount Medicare pays an HMO for each person enrolled and the amount that must be passed on to the Medicare members. When it was first introduced, there was considerable concern, especially among some Senate staff, about whether it was possible to develop prospective per capita costs and adjusted community rates. In addition, there was a serious question about whether Medicare beneficiaries would join an HMO.

In order to determine the answers to these questions, HCFA requested applications for demonstration projects and we submitted a proposal. The project has shown that it is possible to develop prospective average per capita costs. There are more than 300 rating catagories in the rate book we use. They reflect differences in age, sex, disability status, institutional status,welfare status and geographical area.

The project, which we call Medicare Plus, has shown that the methodology for developing an adjusted community rate

is available and workable. It is based on the existing Medicare method of paying HMOs on a cost basis with appropriate adjustments for utilization differences and time and complexity factors.

Finally, our demonstration project and the ones in Marshfield and Worcester have shown that Medicare beneficiaries will join HMOs. On May 23, 1980, Kaiser Foundation Health Plan of Oregon accepted the first application for enrollment under the HCFA demonstration with a plan to enroll 4,000 new Medicare members within the first six months. The membership goal of 4,000 was reached by October, 1980, so a decision was made in November to increase the total to 5,500 new Medicare beneficiaries. This new goal was achieved on January 1, 1981.

It is important to note that this new membership had about the same age and sex composition as the total Medicare population in the Portland area. We made a substantial effort to enroll a representative group of the Medicare beneficiaries in the community. These efforts included the unprecedented step for us of using media advertising to assure wide knowledge of the project among Medicare beneficiaries.

I will describe briefly how the proposal works in Portland. In the Portland metropolitan area it costs Medicare $119.13 a month, on average, for the medical care of Medicare beneficiaries with characteristics comparable to our new members who receive services in the traditional medical care delivery system. This

monthly amount is the adjusted average per capita cost (AAPCC).

Under the demonstration, Kaiser Foundation Health Plan of Oregon (Health Plan) receives 95 percent of the AAPCC, or $113.65. Thus, the federal government saves five percent at the outset. The beneficiary also is rewarded, an incentive that we believe is absolutely critical to attracting more elderly citizens to HMOs by receiving benefits beyond the Medicare A and B package. These benefits include the standard preventive services offered by our Health Plan and result from the requirement that the Health Plan pass along to its Medicare Plus members the difference between the AAPCC and its adjusted community rate.

The adjusted community rate (ACR) is the rate for providing the Medicare A and B benefit package to our Medicare Plus members. It is $94.60. Thus, the difference between 95 percent of the AAPCC ($113.65) and the ACR is $19.05. These "savings" pay for the benefits of Medicare Plus including the coverage of all medicine, deductibles, and coninsurance and the benefits not covered by Medicare, such as routine physical examinations, examinations for hearing, vision care and most immunizations.

The savings also pay for a new service tailored specifically for Medicare Plus enrollees to facilitate their use of our health care delivery system. A new Medicare Plus Member Handbook was developed and written materials were mailed

to new enrollees to obtain current health status information from them. This form was reviewed by a Permanente physician who determined which members needed to be contacted and scheduled immediately for a doctor's appointment.

In addition to the comprehensive supplemental coverage for which Medicare members pay nothing, half of the persons who applied for Medicare Plus were offered a choice of benefit options for which additional rates are charged. This choice was part of the experiment to test which benefit packages offered the greatest incentives to enroll in a health maintenance organization. These additional benefits are priced as follows. For $6 a month, our Medicare Plus members in Portland can receive prescription drugs, eyeglasses and hearing aids, plus the standard A and B package, prescription drugs, eyeglasses, hearing aids, and comprehensive dental care.

We believe there are a number of other provisions that should be included in any Medicare HMO payment proposal. First, HMOs should be required to enroll members without medical review. The only limitation on enrollment should be the capacity of the organization. This is the way we are enrolling in Portland. It eliminates favorable selection by the HMO. Second, HMOs should be able to have their hospital bills processed by Medicare at their option as provided under existing law. This will assure that HMOs are not discriminated against in terms of hospital payments. Third, the cost option for HMOs should be retained.

New HMOs and those with small Medicare enrollments may be unable or unwilling to assume the risk involved. Fourth, HMOs should be allowed to restrict enrollment to persons covered under both Parts A and B. This is what we are doing in Portland and it eliminates many administrative problems and confusion, especially at the beginning of a new program. Finally, an ongoing enrollment system should be established. At a minimum, as persons become eligible for Medicare, they should be advised of their right to enroll in any HMOs that are in the area and they should be informed of the benefits offered by such HMOs.

The Portland demonstration has validated the purposes of S 1509, the bill introduced by Senator John Heinz that would reform the way Medicare reimburses health maintenance organizations (HMOs). The demonstrations prove that if Medicare beneficiaries are rewarded for their willingness to enroll in organized, efficient health care delivery systems by sharing the savings with the Medicare program, they will enroll. The consequences of more Medicare participation in HMOs are long-term cost savings for Medicare, more benefits for the elderly and creation of a more competitive heatlh care delivery system. Competition is stimulated by offering Medicare beneficiaries a choice-- the same choice that Congress now requires private employers to offer their employees.

We believe our demonstration program in Portland has shown that a rational system including prospective payment can be

designed and implemented which will result in lower total costs for the Medicare Program and Medicare beneficiaries than could be achieved in the fee-for-service sector for comparable Medicare benefits.

We wish to commend Senator Heinz and the cosponsors of S 1509 for their understanding of the uniqueness of HMOs and for authoring a payment proposal that recognizes that uniqueness. We believe the bill is well balanced and will benefit HMOs, their Medicare members and the Medicare program. However, the bill has a larger importance than the significant improvement in the Medicare program it will make and the benefits it will provide Medicare beneficiaries. S 1509 is an important step in the efforts of the federal government to recognize cost effective health care delivery systems. It will assist in their growth and development, make them more available to all Americans and is likely to have a beneficial impact on the cost of health care in the United States. Now is a particularly appropriate time for the Congress to act, as it moves to recast federal HMO policy and encourage the development of competition in the health care industry.

STATEMENT OF DR. RUSSELL F. LEWIS, MEDICAL DIRECTOR, GREATER MARSHFIELD COMMUNITY HEALTH PLAN, MARSHFIELD, WIS.

Mr. Chairman and distinguished members of the Committee, we appreciate this opportunity to discuss our experience with prepaid risk contracting under the Medicare demonstration program. I am Dr. Russell F. Lewis, Medical Director of the Greater Marshfield Community Health Plan. Accompanying me are Mr. Mike McDonald, Associate Director of Prepaid Plans and Mr. Gregory Nycz, Project Director of the Medicare demonstration program.

The Greater Marshfield Community Health Plan began as a private venture in March 1971 through the sponsorship of the Marshfield Clinic, St. Joseph's Hospital, and Blue Cross Blue Shield United of Wisconsin. Our program was designed to provide access to comprehensive health care on a prepaid basis to residents of central Wisconsin. We have always operated on a community rating basis and annually hold two 30 day open enrollment periods. During the open enrollment periods residents may join without regard to their health status. The program has no pre-existing illness restrictions nor does it utilize co-payments or deductibles. Professional medical services are delivered by the Marshfield Clinic, a 185 physician multispecialty group practice, and, through affiliation contracts with the Clinic, by all physicians practicing throughout the 6400 square mile service area. We have, since 1974, had a Community Health Center program which assists near poor residents of our service area. For the last four years we have provided prepaid medical services to AFDC Medicaid recipients. Currently we have enrolled 68,000 people representing 43% of the population of the service area.

The Plan exists through a series of contracts linking the sponsoring organizations. Federal qualification has not been sought, and until the time of the Medicare risk demonstrations the Plan had no access to prepaid contracting with the Health Care Financing Administration.

Following a 19 month planning phase, the Greater Marshfield Medicare demonstration program began marketing in April of 1980. Our objective was to develop a program that would be accessible to all Medicare beneficiaries in the service area, regardless of the beneficiaries' health, disability, or institutional status. This was to be accomplished by utilizing continuous open enrollment, and through a special marketing effort to institutional and chronic renal beneficiaries.

Because of delays in getting the program underway, and the considerable interest in the program within the community, inquiries about the program became numerous. In January, 1980, we began establishing a list of the names and addresses of interested beneficiaries. By April, over 1200 names were on the list. The Medicare demonstration program was formally announced on April 14, 1980 and its first participants were covered June 1, 1980. In the ensuing months, local meetings were held throughout the service area and a full-time enrollment office was opened at the Marshfield Clinic. A direct mailing was also conducted to all beneficiaries on our list and to all area Blue Cross Blue Shield United Medex Extended and Medex Preferred policy holders.

I would emphasize that the Medicare demonstration program was enthusiastically received by the Medicare population in our area. In the first three months, over 6000 Medicare beneficiaries joined the Health Plan. This represented over 1/3 of the entire Medicare population in the service area. Since that time, we have expanded the service area to include two more counties. This was done to respond to the interest of the Medicare population and the medical communities in these areas. We have also maintained the continuous open enrollment to ensure access to the program for all Medicare beneficiaries. At the present time, we have enrolled more than 8500 persons in the program. To date, only 116 (about 1%) have voluntarily disenrolled. (Other disenrollments, including death, ineligibility, or eligibility for medical

assistance bring total disenrollment to 445, or about 5%.) Another way of stating the acceptibility of this program to the beneficiary is that over 37% of the beneficiaries in the total service area, and 46% of the beneficiaries of the original area, now participate in the program. In the city of Marshfield, where the Clinic is located, over 65% of the beneficiaries have joined.

There are several reasons why this program has been so well received by the Medicare population in our area. First, we offer excellent benefits, such as unlimited hospitalization, all professional medical services including preventive services, skilled nursing care, home health services, durable medical goods, ancillary health care services, and all necessary out-of-area health services. Second, benefits are provided by all local providers. In almost all cases the beneficiary need not change provider. Third, services are provided for one monthly premium, which is all the enrollee pays -- there are no deductibles or co-payments. Finally, and most importantly to many participants, there are no confusing forms to be filled out. The patients simply show their Health Plan and Medicare cards to receive all needed services.

A very important aspect of the program is that it frees the beneficiary from the anxiety associated with financial uncertainty in dealing with payment for medical services. Because of increasing gaps between what had been paid by Medicare and their actual charges, area physicians generally do not accept assignment for professional fees for services to Medicare patients. While there is supplemental coverage available to Medicare beneficiaries for Medicare co-payments and deductibles, there is no "medi-gap" coverage of the difference between the reasonable charge determinations and actual Part B charges. As the gap between charges and allowable reimbursement has grown in recent years, so have the Medicare beneficiaries' out-of-pocket expenses. In our area, with family income lower than state averages, out-of-pocket expenses are a significant burden on the budgets of many Medicare beneficiaries. Thus, when

provided an opportunity to pay one premium which would virtually eliminate out-of-pocket costs, regardless of health care needs, the enrollees found that very attractive.

While we have managed to provide continuous access to the program for all Medicare beneficiaries in the area, the future of this program is in jeopardy. We have incurred considerable financial losses as a result of the demonstration program. In the first eight months of this fiscal year, the Medicare demonstration has resulted in a $1,149,000 loss to the Health Plan. The Marshfield Clinic and other providers have sustained additional losses. In simple terms, for every dollar the Health Plan takes in it is spending $1.28.

We wish we could say with certainty why we are experiencing these losses, but we cannot. An evaluation team is under contract with HCFA to study the demonstrations in detail. Unfortunately, they have just begun their work and results may not be final for several years. We can today however, give you the benefit of our on-site experience and thoughts. First, there exists a strong possibility of adverse selection. By adverse selection, we mean the enrollment of a group of Medicare beneficiaries that have a greater need for medical services than the average Medicare beneficiary of the area, after adjusting for age, sex, welfare, and institutional status. You do not need any extensive study to come to this conclusion; you simply have to consider the setting and put yourself in the shoes of a Medicare beneficiary. To join you must pay $25.94 per month (less comprehensive alternative Medi-gap policies are presently priced around $20.00). You do not have to change doctors. There are no pre-existing illness clauses; if you join your total coverage for all your medical services commences with your effective date. Preventive services are covered in full. Under the circumstances the only barrier is the $25.94. This can easily be weighed against past or anticipated future medical expenditures. Clearly under these circumstances one would not assume an 'average' enrollment.

The greatest reason for the loss has to do with hospital utilization. Access to the hospital is controlled by the physician and the same physicians provide the care to area beneficiaries in or out of the demonstration program. The insurance status of patients is not identified to Marshfield Clinic physicians we strive to provide quality medicine without regard to financial status. Therefore, it is hard to visualize an explanation other than adverse selection.

A second contributing factor may be increased utilization due to the elimination of financial barriers. Beneficiaries may have been kept from seeking needed medical services on the basis of their fear of how they could pay for hospital and medical services. Many enrollees waited to obtain needed medical care until this barrier was lifted. Whatever the reason(s), a key additional issue relates to whether or not the higher utilization is permanent, or some type of start up phenomena. If beneficiaries are getting needed care in a more timely fashion, what will be the long-term impact?

In spite of the financial problems being incurred by the Medicare demonstration presently, the Health Plan sponsors are convinced that the services provided under it are necessary. Unfortunately, the losses have become so large that if left unchecked the situation could endanger the entire Greater Marshfield Community Health Plan, not just the Medicare demonstration.

Under the demonstration program reimbursement for Marshfield was based on an adjusted community rate development. The adjusted community rate attempts to tie the Medicare rate to the market place by developing use factors that can be used as multipliers on the components of the basic community rate. In our case, we had no experience with which to derive these multipliers for the current fiscal year. Our approach was to use information from other HMO's and from the Health Care Financing Administration. Ideally, actual experience should be used to construct the adjusted community rate. Presently, we are

being paid 98% of the Health Care Financing Administration's estimate of what their costs would have been, in the area, without the demonstration program. With the benefit of a full year of actual experience our projected rate for next year, based on an actuarial method of computation, is about 50% higher than our current rate. While we have not formally computed an adjusted community rate, the indications are that an adjusted community rate based on our actual experience will be as high or higher than the actuarial rate we proposed to HCFA for next year. We do not yet know what HCFA's estimate of their cost will be for our area for next year, although we were told that their average per capita payments in the counties we market the program in have gone up substantially. In spite of this, we are projecting a considerable difference between our projected revenue requirements and HCFA's estimate of their average adjusted per capita costs. We believe it is important to go forward with the demonstration. However, in this year alone it has depleted all of our Health Plan reserves, and puts the entire Plan in a loss position. We are not now in a position to make any reductions in our estimated revenue requirements for next fiscal year.

We believe the average adjusted per capita cost as calculated by HCFA does not reflect the experience of the group we enrolled. We understand that it is permissible under section 1876 to make additional adjustments when evidence of differential utilization within the AAPCC categories exists. We believe this flexibility is critical if HMO's are to contract on a risk basis with the Health Care Financing Administration, and the interests of both the Social Security Trust Fund and the HMO's are to be maintained.

With respect to the Competitive Health and Medical Plan (CHAMP) Act of 1981, we would like to make the following observations:

1) We support the general direction of the Act in that it would provide

access to competitive medical plans for the Medicare beneficiary and encourage risk as opposed to cost contracting. We believe there are advantages to all parties; the beneficiary, the Competitive Medical Plan, and the government.

2) We believe the current method HCFA uses to estimate its expenditures in an area on a prospective basis will not always serve the purpose of the CHAMP Act. We cite our experience as an example of how such a methodology could jeopardize the viability of a Competitive Medical Plan. We would stress that language be introduced to provide flexibility in those cases where the HMO's adjusted community rate (ACR) exceeds 95% of the AAPCC, particularly when the ACR is based on actual experience.

3) We believe both the AAPCC and the ACR need to be continually improved, as operational experience dictates. Use of the ACR should tie Medicare reimbursement to the non-Medicare marketplace, and has the advantage of being based on the actual Medicare population enrolled. If Competitive Medical Plans offer more efficient delivery of health services, they should not be penalized for enrolling those most in need of care; on the contrary, they should be encouraged to do so. If the AAPCC is below the ACR, then for the sake of the beneficiaries alone, some review and exception procedure should be available to resolve the discrepancy.

Mr. Chairman, in summary our experience under the Medicare demonstration program has clearly shown that many Medicare beneficiaries are interested in receiving this medical care under the auspices of a Competitive Medical Plan. However, a single, unflexible approach to premium rate determinations will not serve the mutual interests of all involved parties. We are most willing to share our experience under the demonstration program in more detail. To that end we will avail ourselves to the Committee staff at your request.

Thank you.

STATEMENT OF JOHN P. O'CONNELL, EXECUTIVE DIRECTOR,
FALLON COMMUNITY HEALTH PLAN, WORCESTER, MASS.

The Fallon Community Health Plan is a Federally qualified Health Maintenance Organization located in Worcester, Massachusetts. It is jointly sponsored by The Fallon Clinic and Blue Cross of Massachusetts. It was funded with the help of a $650,000 in Federal Initial Development Grant and a $500,000 grant to expand its geographic area of coverage. It was authorized to use 1.6 million dollars in Federal loan money. It has, however, only used $160,000 of this amount. The Plan became operational on Febuary 1, 1977 and Federally qualified on November [illegible], 1978.

Worcester is the second largest city in Massachusetts. It has about 175,000 residents and there are about the same number in the immediate environs that make up the Fallon Community Health Plan service area.

The Plan is a one group, "Group Model Health Maintenance Organization." All services to Plan members except for emergencies are either provided by or arranged by the physicians of the Fallon Clinic. The Fallon Clinic has existed in Worcester for over 50 years. It has 60 full time physicians practicing at three large modern Clinic sites. It must be considered to be in the mainstream of American medical practice. Whatever success the Fallon Community Health Plan has had is due in a

very large part to the reputation of the Clinic for high quality medical care.

The other co-sponsor of the Fallon Plan is Blue Cross of Massachusetts. It is a Hospital Service Corporation and Part "A" Medicare Intermediary. It is a companion in operations of Blue Shield of Massachusetts, a Medical Service Corporation and Part "B" Medicare Intermediary. Together Massachusetts Blue Cross and Massachusetts Blue Shield constitute the largest Hospital-Surgical-Medical carrier in the Commonwealth.

In four and one half years of operation, the Plan has grown to cover 34,000 persons including both subscribers and dependents. In 1980 it reached a break even point in operations. Its membership includes 27,600 employer group numbers, 800 Medicaid members and over 5,600 Senior Plan members enrolled under our experimental program.

At a time when our total membership was only 5,000, we responded to a HCFA request for proposal. At the time we had no existing program for persons over 65 years of age. We proposed to make available to Medicare beneficiaries, in our service area, a comprehensive set of benefits in lieu of traditional Medicare coverage. These benefits were to include all covered Part A and B services, all deductible and co-insurance items, preventive

services, such as physical examinations without sign or symptom of illness, nutrition service, social service, refractions, eyeglasses and prescription drugs subject to a $1.00 co-payment charge. Our monthly dues for services were determined in accordance with a protocol agreed to by HCFA. Basically it was a cost based adjusted community rate. HCFA was to pay no more than 95% of the adjusted area costs and the member was to pay the balance. In year one and year two of the experiment, the member portion has been $7.50. The HCFA portion has been approximately $120.00.

We enrolled 3.600 Medicare members in year one of the program and in year two that number increased to 5,600 approximately 10% of Medicare beneficiaries in the area.

In entering into this program, we hoped to demonstrate certain things. First: that a Plan such as the Fallon Community Health Plan, "Senior Plan," will lead to increased receptiveness by qualified Health Maintenance Organizations to enroll Medicare (Title XVIII) beneficiaries.

We think the experiment has been good for us. It supplied members and a secure cash flow at a crucial time in our development. Finances are very tight, but nevertheless successful. We hope to continue this program, authorized

by legislation. This is not only for the benefit of the Plan but for its "Senior Plan" members who have come to rely on it for health care services. We believe that other programs would want to emulate our actions and our success.

Second: we hope to demonstrate that a Plan such as the Fallon Community Health Plan, "Senior Plan," is cost effective. We think we have done this. The government is saving 5% on the cost of covered part A and B services. The value of benefits in addition to covered part A and B services provided each member including deductible and co-insurance items, preventive services, refractions and prescription drugs is $39.23 per month. The member pays only $7.50 for these benefits.

We have experienced some different utilization patterns than were originally anticipated. For example, we projected 2,300 days of hospitalization per thousand members enrolled and have experienced 2,700. This corresponds to over 4,000 hospital days per thousand population of persons over 65 years of age in the state. Out-patient visits, however, were slightly lower than we anticipated. We believe that adjustments within the protocol could accommodate these differences in future years, as we enter experience into the capitation calculation. of the original 3,500 members that enrolled in the first open

enrollment period all but 206 have received services at the clinic. We feel that the somewhat high rate of hospitalization is due, in part, to previously undiagnosed pathology discovered on the initial clinic visits. The clinic is now contacting the remaining 206 enrolled persons to arrange physical examinations. When this is complete, it is felt a certain backlog of unmet need will have been met.

Third: what we hoped to demonstrate was that a Plan such as the Fallon Community Health Plan, "Senior Plan," can attract Medicare beneficiaries to enroll in a prepaid system. We have, infact, enrolled 10% of the Medicare population of our area within a one year period. The marketing was by an unlimited open enrollment without underwriting and without exclusions for preexisting conditions. We advertized in the newspapers, conducted open meetings at the Clinic and asked each Blue Cross medex subscriber to fill a dual choice election card.

The fourth and final thing we hoped to demonstrate was that a Plan such as the Fallon Community Health Plan, "Senior Plan", can be offered successfully in a Health Maintenance Organization of moderate size. We think that we have done that.

In conclusion, we endorse the proposed legislation.

It will save the Federal Government money and improve the living standard of our senior citizens.

I must say that I have some reservations regarding some of the provisions of the bill. I do not endorse the so called rate book approach to rating. I believe that each years capitation should be based on the characteristics of the population covered the previous year. To do otherwise would make budgeting complex and income unpredictable.

I do not believe that there should be high and low coverage options or programs for persons with part B coverage only. We have only one program at one rate of dues for our under 65 population and one administrative structure to administer it. Explaining differences in coverage to persons over 65 is extremely difficult. Imagine explaining to a Senior Citizen who is not familiar with health care coverages that there are in fact four options, a high option and a low option for persons with part A and part B and a high option and a low option for people with part B only.

I do not think that there should be institutional or health status adjustments to the capitation. The information regarding these items is not in the Medicare files. I know of no reasonable satisfactory or reliable way of accumulating

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it. Also, there is a danger that HMOs would be penalized in subsequent years for keeping their members out of institutions.

The beneficiary's medicare health insurance card should show that he or she is a Health Maintenance Organization member. The words "Part A Hospital Insurance" and Part B Medical Insurance" should not appear.

Finally there is one area where we have experienced some severe problems. That is assuming liability for persons who are hospitalized on the day that their coverage in the Health Maintenance Organization becomed effective. It is traditional for health insurance carriers and Health Maintenance Organization to assume liability for an episode of hospitalization if the member is covered on the day of admission and to cover the patient until discharge, even though the patient may transfer his coverage to another carrier in the interim. We have covered a patient who was hospitalized four months prior to the date that his coverage became effective and he still remains hospitalized now, seven months later. We are paying his bills, however, we feel that this is an unreasonable area of exposure. We should not be responsible for the institutional bills for admissions prior to the date that coverage becomes effective. On the other hand we should be responsible for admissions that occur while

coverage is in effect but continue after coverage terminates.

We feel that by this experiment we have shown that the program works. We have provided needed services to a large number of elderly persons. We have saved money for the government and our members. We think that by meeting a backlog of unmet needs we have improved their health status.

I hope that you will propose and pass the bill here under consideration. If you do, you will be taking a giant step toward meeting the needs of our aging population and toward cost containment in the delivery of health care.

Thank you for your kind attention.

Senator HEINZ. Thank you very much, Mr. Coe.

Now, between the four of you, you represent all of the HCFA demonstrations of this kind now ongoing, and two of you have been able to offer in particular, very generous packages to your medicare enrollees.

But, and I am thinking of the Group Health of Puget Sound and of Kaiser in Portland. But in your case there has been some data to indicate that better than average medicare health risks have enrolled in your plan.

First of all, is that, or is that not, true?

Mr. COE. Speaking for Puget Sound, and I will let the others speak for themselves, speaking for Puget Sound, I think we would disagree based on the experience we have had to date. What you are referring to is the Egger's paper which HCFA did following our first year experience under our risk-basis contract which started in October 1976. We have concerns with the methodology used.

Our own experience demonstrates a couple of things. One, our utilization of the over-65 is far in excess of what we forecasted. We feel this is a very clear indicator that we did not enroll medicare beneficiaries healthier, on average, than those in the community.

Second, there has been a study done in Seattle by Tom Bice of the University of Washington where he looks at the health status of the medicare population in the city of Seattle, and determines that those medicare beneficiaries that are enrolled in Group Health were no healthier than the medicare beneficiaries existing in the rest of that population, the city of Seattle.

Senator HEINZ. Dr. Greenlick, what about your organization?

Dr. GREENLICK. Well, Mr. Chairman, I think it might be useful to explain the way our demonstration works and, by the way, we are very pleased to be able to talk about it. It is a very exciting process, to be allowed an opportunity to bring 6,000 more medicare beneficiaries into the Kaiser-Permanente program in the Portland area.

We, too, had heard about the HCFA study of Seattle, and I understand there is to be released a study of Portland, and the other demonstration sites. Therefore we felt compelled to make sure that we broadcast the enrollment offer in a clearly understandable way to the total eligible population of beneficiaries in the Portland metropolitan area.

In our marketing program we told the story of the demonstration on television, by newspaper, through the senior citizen centers, throughout the entire five-county enrollment area. We were on television 155 times over a 3-month period. We were in 17 different newspapers. We visited senior citizen centers and brought senior citizen advocates into our planning as early as possible.

We believe that 90 percent of the people who were eligible to join the program were offered the opportunity to join the program. We accepted into the program the first 6,000 people who applied during a 6-month open enrollment period without regard to any medical barrier, with no examinations. We were not looking for anybody special.

We enrolled 4½ percent of the population of the medicare beneficiaries in Portland. We did, indeed, have a rich option because the Kaiser program in Portland appears to be much more cost-effective than the fee-for-service in the area.

We offer to the special project beneficiaries the benefits that are offered to all of the other Kaiser-Permanente beneficiaries, but we were able to offer it to them at no monthly charge because of the savings, because of the difference between 95 percent of the AAPCC and the ACR. So the beneficiaries came in at no monthly charge. We have data to indicate now that their health status, at least in terms of their own functional evaluation of their health status, is essentially the same as the rest of our over-65 members.

We also have information from an Oregon health survey to indicate that the Kaiser beneficiaries who are over 65 generally are more disadvantaged in terms of health status than the over-65 population in the Portland area.

Senator HEINZ. How do you account for the data that is being developed?

Dr. GREENLICK. I think the testimony that you heard earlier in the day by the beneficiaries may be one of the reasons to account for it. The study done by HCFA does not deal with the question of health status. It deals with the question of the utilization of health care services in earlier years. It is possible that the people most likely to select our program are people who probably were disadvantaged in terms of health care use and probably had less care available to them because of the financial barriers, and when they come into the program, at least in the early years, they have some unmet needs.

We think it will probably wash out quickly, but we think that adding health status as in your bill may be one of the ways to deal with this problem.

Senator HEINZ. Well, you have correctly noted that in the bill we have on the very first page at the very bottom, it says the Secretary shall define appropriate classes of members based on such factors as age, sex, institutional status, disability and health status, and the rate for each class should be equal to 95 percent of the adjusted average per capita for that class.

This is the purpose of having the words "health status" in there, to assure ourselves that we do not get some kind of disproportionate distribution of people. It would be a financial calamity for medicare if the healthy people went into HMO's and left the unhealthy people with good old fee-for-service medicare. The medicare program has enough problems as it is without adding that kind of problem to it.

Have any of you other gentlemen a belief that you would achieve anything other than what appears to be favorably good results, with that kind of requirement that I just mentioned, or is it a defective part of the legislation?

Dr. Lewis or Mr. O'Connell.

Mr. O'CONNELL. Well, we want to have a representative population and we want the rates to reflect a representative population and we want there to be a good and sufficient way of judging that. We think that there is time to write regulations between now, given the passage of the bill, between now and the time that the bill was passed, so that that could be accomplished, and we do endorse what you suggest.

Senator HEINZ. Dr. Lewis.

Dr. LEWIS. Well, the Marshfield experience has been somewhat different than the others in the sense that we have been losing money so rapidly that we are in danger of dropping out of the contract.

Senator HEINZ. Would you please pull the microphone closer?

Dr. LEWIS. Things moved so rapidly that we really, to date, do not have all the information we would like as to why things happened the way they have been happening, and whether it is a question of what the AAPCC is in a rural area in contrast to an urban area. We do not know. We do know in our group that we have had open enrollment for everybody every day of the week for the past year. We are pretty convinced that we have had the bad risks join.

I do not know what the data is but I would be surprised if it did not show that that is part of the problem that we are facing as well as the fact that I know, because we had a delay in getting the program started, that we had a lot of folks waiting to join the plan and many of those folks were postponing elective surgery. It may be that this is an initial utilization phenomena, but we are not sure about that, and we are concerned about the fact that there has to be some mechanism for someone to decide that there may be another way of reimbursing the group.

If you stick to the AAPCC without exception, it will be impossible, the financial losses will bankrupt some HMO's.

Senator HEINZ. May I ask Dr. Greenlick and Mr. Coe, do you believe that the scope of your benefit packages, which in effect are pretty darn good, would be more limited if you enrolled an absolutely representative population of the medicare population?

I gather from what you have said you feel you have a representative population. So I assume that the answer to that question, but I would like it for the record, is that your benefit packages would not be more limited.

Is that correct?

Dr. GREENLICK. Yes, certainly the benefit package we offer is precisely the benefit package we offered to the other 15,000 Kaiser-Permanente members who are also medicare beneficiaries but are not in this experiment. The only difference among them is that for the group members, 5,000 or 6,000 of them, the groups pay the monthly premium. The individual members, 8,000 or 9,000, pay individually at a rate of about $17 a month. For our medicare-plus experiment, thus far, they pay nothing.

In other years they may pay a small amount depending on the savings. We feel having this comprehensive benefit package does make the Kaiser-Permanente program particularly attractive to people but it strikes us it would make it more attractive to people who are more in distress.

Senator HEINZ. You have four different packages, a low option, $11 premium cost applying to medicare parts A and B, without copayment or deductible, plus routine offerings, outpatient mental health care, and all the rest, up to the highest option which costs an initial $15.81 a month, and provides this comprehensive benefit-plus coverage for eye care, dentistry, and so on.

Of those four plans that you offer, which benefits or package benefits, seem to be most attractive?

Dr. GREENLICK. First I would like to comment on the terminology. The low option-high option is meant usually to refer to something entirely different. The plan you refer to as the low option is what is usually referred to as the high option. It provides——

Senator HEINZ. It provides a lot. If it will help you, we will say high and highest, with two stops in between.

Dr. GREENLICK. Standard and some additions would be a better description.

As you know, we offered this as a benefit experiment because we were intrigued to find out what would encourage enrollees to join the Kaiser-Permanente program. Half of the folks were not offered that. They were only offered the comprehensive benefit package. Half of the people were only able to join at no premium, but to get our standard total medical care coverage. They only ended up paying $2 a visit for all medicare covered services.

The other half of the plan were offered zero dollar a month coverage for the comprehensive benefit package, $6 a month for drugs, eyeglasses, and hearing aids, $10 a month for dental, and $16 a month for total. In each of those situations, about half of the people who asked for enrollment information ultimately enrolled in the plan, almost exactly the same percentage.

So it was not the benefit experiment that encouraged them to join the Kaiser-Permanente program. But, to answer your question, of the people offered the additional optional benefits, almost 80 percent of them selected one of those optional benefit alternatives. About half of that group—the 80 percent—selected the $6 a month package for drugs, vision, and hearing aids; and about half of them selected the $16-a-month package for drugs, hearing aids, vision, and dentistry.

So it was a very attractive package when they were offered it. But the same proportion of both groups did join the program.

Senator HEINZ. So it was not, per se, as far as your experience shows, a factor in whether or not people joined up as opposed to not joining up?

Dr. GREENLICK. We believe they were joining to have the option of enjoying the coverage and enjoying the savings of $16 or $17 a month that were passed on to them.

Senator HEINZ. Mr. Coe, going back to the original question, do you agree with the original statement that I made?

Mr. COE. Well, basically at Group Health we offer two options, a low option, which is basic medicare, parts A and B, and a high option, which is full comprehensive.

It is basically the same as the basic plan we offered to all nonmedicare patients. I think our experience has been the same as that of Portland.

Many want the high option. They want the comprehensive package. We do one thing that the rest of the plans do not do. We do health screening with regard to drug use. We look at drug utilization as a determinant in terms of a risk factor, as an indicator of other problems.

I think our conclusion is probably going to be that it is not a very good indicator and we may even consider eliminating it.

Interestingly, those people who have not passed the health screening have been a very small percentage, but those who have

not passed it and therefore been ineligible for the high option, in many cases chose not to take the low option. The lock-in is the primary reason they have not chosen to take the low option. They have to change providers to come in.

Over 90 percent of those seeking enrollment in our program are selecting the high option plan. As it was identified at this table by the consumers, it eliminates the cost barriers, eliminates the paperwork, and therefore is rather attractive. I think the point that Mr. Greenlick made is a very important one.

A comprehensive package like that is going to be very attractive to the high users. So I am confident that under the law as you are proposing it, that we will see a very average risk selection in terms of the community, in terms of the health status of the medicare beneficiaries in the community.

Inclusion of the health status factor, to the extent that it addresses our problem, I think is useful.

Senator HEINZ. In your opening statement on behalf of the panel, you indicated two problems. You indicated there was a problem for the AAPCC, and you indicated some concern about the possibility of a cash rebate as one of the options in the plowback provision.

Now, you may be speaking for some other individual or yourself in particular. So either you or someone else can answer.

Mr. COE. I think we all share common concerns. The retroactive reimbursement of the present law—we are not a demonstration project. We are a section 1876 risk-based contract.

Senator HEINZ. You are different from the other three.

Mr. COE. Yes; we are not a demonstration project. Retroactive reimbursement is not the mode HMO's normally work in. We quote a rate and we are at risk with regard to that group. We would like to treat the medicare group the same way. That is what your proposal does. That is what the present demonstration projects are doing. The retroactive adjustments, literally 2 and 3 years later, play havoc with your ability to pass savings along to your medicare beneficiaries.

We have had adjustments downward of up to 14 or 15 percent from initial estimates and you can get two or three of those spread out over a 2- or-3 year period.

Senator HEINZ. That is, if you do it retroactively.

Now we are doing it prospectively. I thought you said that you had some kind of a problem with our use of the average area per capita cost.

Mr. COE. I do not think we said we had a problem with the use of the AAPCC. We are saying that all of the intricacies of that methodology have not been worked out. We are gaining experience. We are learning. I would like to compare what we are doing now with what we did 5 years ago.

Senator HEINZ. Does anybody care to add to that?

Dr. GREENLICK. We have reservations on certain of the elements of the AAPCC But I would certainly like to second what Mr. Coe has said. We are now gathering the data and we think it is possible to work out the issues, and we believe the issues will be worked out.

Senator HEINZ. You will probably be asked about that tomorrow.

Dr. GREENLICK. I would like to comment on the cash rebate question.

One of the earlier demonstrations we have been involved in in my time as research director was the OEO neighborhood health center project. We were one of the first HMO's to be involved in poverty medical care going back to 1967. I could imagine certain instances where a rebate would make some sense, because we think one of the basic principles of these demonstrations is that we are sharing the savings of a more efficient medical care program both with the Government and with the beneficiaries. Certain beneficiaries such as the poverty beneficiaries and perhaps others might not have opportunities to share in their savings if there were not the possibility of a rebate.

We see possible real dangers with rebates but I do not think we would want to see that excluded.

Senator HEINZ. Mr. O'Connell.

Mr. O'CONNELL. We feel that the benefit package should be as comprehensive as possible. First of all, the health question should have the widest range of choice of treatment modality. That is very important.

That they be able to choose the lowest cost appropriate medical care that is needed. Second, it is also important that the HMO has an actuarially sound group of people to enroll. Fallon has enrolled 11 percent of the people over 65 within our service area. We are absolutely convinced that the reason we have been able to enroll such a large percentage is that the people who are members really want these extended benefits.

You heard Mr. Kay this morning testify. We need the volume and the numbers so that we are not exposed to abnormal risks from a single catastrophic case. If we were covering just 200 or 500 people, we could be wiped out by some of these cases that cost such an extreme amount of money. So we are in favor of requiring that we have to pass these savings on to the members in favor of extended benefits.

We are not in favor of cash rebates.

Senator HEINZ. It sounds like you could pass benefits along for free. What is the difference between extending benefits and not extending benefits and rebating the cash?

Why is it that there is a difference?

Mr. O'CONNELL. The difference is in practice. If we offer members the appropriate care that they need for their illness or their disability, then perhaps we are going to be more effective and get them to come in and receive the treatment that they need. If we are in an operation where people that really need care are the only ones that use the additional benefits, the ones that are not coming for care choose to get the rebate, then we have a developing, literally, class system and we feel basically that there is only one class of member, one class of benefits, the very best.

I might add to that, we are a small program. We are not Kaiser. We cannot have 15 different options in Worcester in a clinic of 60 doctors.

Dr. LEWIS. I want to go back and address the AAPCC in our experience because it is, in our opinion, a real problem that somebody has to address before it becomes the law of the land.

We do not know what the problem is but we know that we are getting just slightly more than 50 percent of—for the same thing that people at St. Louis Park, which is a comparable program, comparable fees, and yet we are giving the same kind of service.

We think something has to be looked at to see why this $75 and $140—whatever the figures are, why this discrepancy occurs.

All we are asking is, before this becomes finalized, as a criteria in the law, if this cannot be reevaluated as to why, whether we are peculiar in Marshfield, as everyone tells us, or whether it is a rural phenomenon, or some other area that needs to be straightened.

Senator HEINZ. Regarding the Marshfield phenomenon, it is my understanding that it is an IPA in a relatively rural area. The Marshfield Clinic served a significant segment of the medicare population residing in that area even before you entered into a contract with HCFA.

In a sense, you know, the medicare reimbursement being tested by HCFA really need not have been tested for you to offer better benefits to your medicare beneficiaries.

I therefore pose my first question: Why did Marshfield decide to participate in the demonstration program?

Dr. LEWIS. Because in the 8, 9, or 10 years we were in existence, the major complaint we heard from our people and by far the major complaint was, why do we have to, at age 65, get onto that medicare arrangement where we have to fill out these forms, and we have been so happy with this prepaid plan.

We would love to continue. We got that day after day from everybody. So for several years we have been promising them that we would make some effort to get into it. This looked like the earliest opportunity. I think we jumped in. We thought it made sense.

Senator HEINZ. If you had to do it over?

Dr. LEWIS. We could not afford to do that.

Senator HEINZ. What would you do?

Dr. LEWIS. We would probably have developed a wraparound program which may be the alternative.

Because we cannot stay in this thing unless we get more help from the Federal Government.

Senator HEINZ. Could you explain that?

Dr. LEWIS. Taking assignment from the patients and setting it up so we can get assignment paid and then in addition we would cover the services not covered by medicare and they would have to pay a fee for that—but hopefully a reasonable fee.

Senator HEINZ. Let me particularly, Dr. Lewis and Mr. O'Connell, ask you this: Some people, including myself, feel that the Federal Government has never really found a successful quality assurance mechanism for medicare and medicaid providers, although we have tried a few things. Therefore, in the CHAMP bill, S. 1509, some different criteria for quality assurance has been included as well as a provision that competitive medical plans must have a quality assurance program that they, themselves, have designed with simply the approval of HHS.

Quality assurance in our competitive medical plans would be accomplished through the requirement that at least one-half of the

enrollees be nonmedicare and nonmedicaid beneficiaries and that the plan must have at least 1,000 enrollees.

My question to you, Dr. Lewis, and Mr. O'Connell, in your view, are the membership quality assurance requirements reasonable and in particular, Dr. Lewis, are these standards workable for an IPA-type medical plan?

Dr. LEWIS. I think they are very reasonable, and very workable. I do not think there would be any problem with that.

Mr. O'CONNELL. I agree entirely, quite reasonable and quite workable.

Senator HEINZ. Very well. I do not know if Senator Cohen or any other members have any questions for you. Maybe people are saving up for you tomorrow in the Finance Committee. That completes all of my questions.

You have been very patient. If you have any last thoughts you would like to get on the record, don't make your powder wet for tomorrow, we would be happy to have them.

Dr. GREENLICK. I would like to share a Christmas card that I received as project director. It contained the usual Christmas greetings but it has the note inside. It says,

I am 76 years old and a recent widow. It gives me peace of mind knowing no M.D. will do surgery on me unless it is absolutely necessary. There is no way in words that I can say how thankful I am.

Senator HEINZ. Dr. Greenlick, are you a surgeon?

Dr. GREENLICK. No. I think I am an antisurgeon.

Senator HEINZ. What is your specialty?

Dr. LEWIS. Obstetrics and gynecology.

Dr. GREENLICK. Medical care organization is my specialty.

Senator HEINZ. We will note the Christmas card in the record, and hope the AMA takes it on its own recognizance.

We thank you all. We thank you for your patience because we have been interrupted a number of times.

[Whereupon, at 4:50 p.m., the hearing adjourned.]

[The following material was submitted for the record:]

HMOs AND OTHER PREPAID HEALTH PLANS

BACKGROUND

The term "health maintenance organization" generally describes an entity which provides specific health services to its members for a prepaid, fixed payment. In one respect, this arrangement is like a traditional health insurance program in the fee-for-service system. A monthly payment insures some portion of the costs of health services that a subscriber may incur during a period of time.

However, an HMO is different from the fee-for-service system and traditional health insurance programs in at least three respects. First, it is different in its approach to payment to providers of health care services. In an HMO, providers are at risk and are not reimbursed for each of the services they provide, as physicians in the fee-for-service system generally are.

Second, HMOs can be distinguished from a traditional health insurance program in the fee-for-service system by either providing directly or arranging to have provided those services specified in the HMO subscriber contract. A member of a Blue Cross/Blue Shield plan or other private health insurance plan in a fee-for-service arrangement does not have services provided by the plan. Rather, the member secures his own provider or providers whom the plan might then pay.

Finally, a member of an HMO most often is allowed to choose his own physician within the plan. However, the member is not allowed, except under extraordinary circumstances of medical emergency, to seek care from physicians or other providers outside the plan.

These aspects of the HMO concept are alleged to give the HMO a capacity and a financial incentive to control the utilization of health services so as to reduce overall health care costs.

The term, health maintenance organization, was first advanced by Dr. Paul Ellwood in 1970, and was intended to include two basic HMO models: (1) the prepaid group practice model, and (2) the individual practice association or medical care foundation model. In both models, the HMO receives periodic payments of fixed amounts in return for the services it provides to HMO members.

Under the group practice model, however, most medical services are provided by physicians who are members of a group practice. Some physicians may be either employees of the HMO or members of a separate entity which contracts with the HMO to provide medical services to HMO members. Physicians in these arrangements are paid in a variety of ways -- the two

most common being either by salary, or as a group where the HMO pays the group fixed payments per member each month.

Under the individual practice association or IPA model, physicians in a community, generally a county, or group of counties, contract with the HMO to provide medical services out of their private offices, which can be either solo or group practices. Physicians in IPAs are generally paid on a modified fee-for-service basis with retrospective adjustments based on performance by the HMO and the individual physician. In other words, the fewer expenses incurred by the HMO by the end of the year, the higher the income is likely to be for physicians at that time.

Group practice HMOs either own their own hospitals, as is the case for most Kaiser Foundation Health Plans, or arrange for hospitalization for members at one or more community hospitals. The latter arrangement is the most common among group practice HMOs, and is the prevailing practice with individual practice association HMOs.

Because providers are at risk and are not reimbursed for each of the services they provide, HMOs are intuitively attractive as a means for cost control because they alter the usual economic incentives in medical care and give providers a stake in holding down costs. Evidence tends to support this theory, particularly when the response to HMO incentives is compared to the prevailing system of third-party reimbursement for providers. Studies have found that the total cost of medical care (i.e., premium plus out-of-pocket costs) for HMO enrollees is lower than it is for comparable people with conventional insurance coverages. The lower costs are clearest for enrollees in HMO group practices, where total costs are from 10% to 40% below the costs of conventional insurance enrollees. Although the evidence is relatively meager, by comparison, costs for enrollees in individual practice associations appear no lower than for enrollees in conventional insurance arrangements.

Most of these cost differences have been found to be the result of hospitalization rates lower than those of conventionally insured populations. And these lower hospitalization rates are due almost entirely to lower admission rates; the average length of stay of a person in a hospital shows little difference in the HMO as opposed to the conventional arrangement. For example, the last National HMO Census of Prepaid Health Plans noted, for 1979, the inpatient hospital utilization rate for all HMO plans was 412 days per 1,000 members per year. This compares to an average of about 730 days per 1,000 Blue Cross enrollees nationally in 1978.

In addition, physician visits per member per year for all HMO plans averaged 3.4, and total health plan encounters, including those with the HMOs' nurse practitioners or physicians assistants, per member per year for all plans averaged 4.5 in 1979. The national average was about 5 physician visits per person per year.

DEFINITIONS: TYPES OF HMOs

Group Practice Model (GP) refers to an HMO that contracts with a group of health professionals for the provision of health services to HMO members. The health professionals work out of a common facility, pool their income from practice as members of the group, distributing it among themselves according to a pre-arranged plan. If the HMO employs its physicians on a salaried basis, it is also referred to as a staff model.

Staff Model SMO is similar to the prepaid group practice HMO model except that the physicians are employees of the HMO, rather than independent contractors.

Individual Practice Association Model (IPA) -- An IPA is an organized group of independent practitioners and/or small groups of physicians gathered together for the purpose of deciding on what basis they shall contract for their services. In an IPA-type HMO, the HMO entity contracts with the IPA organization or directly with individual health professionals who agree to provide health services to HMO members in accordance with a compensation agreement. The health professionals work out of their individual offices and are usually reimbursed by the IPA on a fee-for service basis.

Network Model -- The network HMO contracts with more than one medical group and/or IPA organization to deliver care to HMO members in different geographic locations. Each medical group or IPA provides a full range of comprehensive benefits and is contractually linked to a central point of accountability. The benefit package and premiums for each of the medical groups and IPAs in a network are often identical. The prepaid group practice network is characterized by separate and independent delivery points, of which the HMO member selects one to receive all health services. Most of the network programs in existence were developed by Blue Cross and Blue Shield Plans. The HMO Act does not specifically recognize this model and classifies such programs as IPAs.

Competitive Medical Plan (CMP) -- is a public or private entity, organized under the laws of any State, which is a federally qualified HMO; is licensed as an HMO in the State in which it operates; or an entity that: 1) assumes full financial risk on a prospective basis for the provision of health care services, 2) provides physicains services either directly or through contract with physicians, 3) provides to enrolled members at least the medical and hospital benefits provided by Parts A and B of Medicare and out of area coverage, 4) is compensated for the care of enrolled members on a periodic basis without regard to date, frequency, extent, or kind of services rendered, and 5) has made adequate provision against the risk of insolvency.

HCFA PROSPECTIVE RISK CAPITATION DEMONSTRATIONS: OVERVIEW

In May of 1978, HCFA issued a request for proposals (RFP) to develop and implement demonstrations in prospective risk capitation contracting for Medicare beneficiaries. The RFP was designed to support increased HMO enrollment among Federal beneficiaries and the promotion of cost efficiency and competition in the health care marketplace. Seven contracts were awarded in order to test alternative prospective risk reimbursement methodologies, demonstrate incentives to enroll by returning HMO savings as increased benefits and/or by contracting for the same or increased benefits at rates lower than fee-for-service costs.

The overall cost for these demonstrations is $3,892,035; of which $1,396,067 has been for the development phase. Each contract consisted of developing the operational plans (Phase I) for actual implementation of the demonstration (PhaseII) for a period up to three years. Phase II for each project was to be implemented, at the option of HCFA, upon satisfactory completion of Phase I.

HCFA DEMONSTRATIONS: INDIVIDUAL DESCRIPTIONS

Marshfield Medical Foundation

The Greater Marshfield Community Health Plan (GMCHP) is a non-Federally qualified HMO which was established in 1971. It is sponsored by the Marshfield Clinic (a 160-physician multi-specialty group practice), St. Joseph's Hospital, Blue Cross of Wisconsin, and Surgical Care Blue Shield. The Plan services an enrollment of over 55,000 residents in rural central Wisconsin, incorporating all or parts of seven counties. The Marshfield Medical Foundation is the incorporated entity which was established by GMCHP to exclusively administer the Plan's Federal programs.

Under the demonstration, GMCHP is being offered to 18,000 Medicare beneficiaries through a continuous open enrollment. GMCHP has developed special marketing methods and materials to accomodate the Medicare beneficiary. Numerous public and senior citizen organization meetings have been held, and a special enrollment office has been established at the clinic and medical and educational activities targeted at Medicare beneficiaries have been pursued. These efforts have resulted in enrollment of approximately 6,000 Medicare beneficiaries as of August 1980 with a high expectation of reaching 12,000 by March of 1981. Of course, this enrollment success is expected inasmuch as the Marshfield demonstration includes the major providers in the service area.

GMCHP benefits, which encompass and extend Medicare benefits and eliminate deductibles and co-pays, are financed by a fixed prospective capitation payment from HCFA combined with an enrollee premium. The capitation rate has been derived from an actuarial adjustment of the GMCHP community rate which reflects the greater per capita utilization of services by the Medicare population. HCFA's capitation payment for the first contract period was set at 99 percent of the Area Prevailing Cost for non-chronic renal disease (CRD) beneficiaries and 98 percent for the second contract period which begins October 1, 1980. A special capitation rate for the CRD beneficiaries has been set at 95 percent of the CRD AAPCC for both the first and second contract period.

The Medicare component of GMCHP is fully integrated into the Health Plan. Services to Medicare enrollees are supported by the Plan's medical records, quality assurance, and management information systems.

Medicare enrollment as of March 1981: 7796

Fallon Community Health Plan

The Fallon Community Health Plan is a qualified HMO jointly sponsored by the Fallon Clinic and Blue Cross of Massachusetts. As of July 1979, it served 13,000 group members, including 200 AFDC beneficiaries, in the Worcester area. Fallon is a one-group staff model HMO, expected eventually to accommodate over 27,900 members. By the end of its demonstration contract in December 1982, Fallon hopes to enroll a total of 4,747 Medicare beneficiaries with Parts A and B as well as Medicaid Old Age Assistance recipients.

Marketing efforts to date have been targeted at group and non-group "Medex" subscribers, offering to them a dual choice between their current coverage and that available through the Senior Plan. Senior Plan marketing efforts began on February 7, 1980 and within a month, the first year enrollment projection of 3600 had been achieved. The marketing strategy focused on a "Health Fair" at the Fallon Clinic held prior to their enrollment campaign. Presentations and talks were presented about the Plan, tours were given of the Fallon facilities, and booths were set up dealing with a variety of topics related generally to the health and welfare of the elderly. Approximately 4,000 people attended. Five open houses were also held and newspaper ads were run containing a card that interested readers could send in and receive a brochure and application. Fallon received over 3,000 returned cards. In addition, Fallon obtained a mailing list of Medicare supplemental policyholders from Blue Cross of Massachusetts, which they used to disseminate literature in Worcester County.

Fallon's rates are based on an adjusted community rate (ACR). During the first year, Fallon's ACR was sufficient; i.e., 90 percent of the AAPCC, to permit the coverage of several additional benefits at a $7.50 monthly premium. The additional benefits include: prescriptions with $1.00 copayment, eye examinations and one pair of eyeglasses, preventive services, and reduced coinsurance and deductible expenses. This generous benefit package probably explains the unusual success of Fallon's enrollment efforts. Fallon hopes to be able to offer beneficiaries the same benefit package at the same premium when new rates to into effect in January 1981.

Medicare enrollment as of March 1981: 5495

Kaiser - Portland

The Kaiser Permanente Medical program is the largest nongovernmental health care provider in the world. The program provides comprehensive care to over 3.6 million persons in seven geographic areas. Kaiser is conducting the Medicare demonstration in the Oregon Region which currently serves more than 220,000 persons or about 20 percent of the population of the Portland-Vancouver metropolitan area. The Oregon Region maintains two hospitals, several ambulatory care facilities, a mental health center and three dental facilities. Kaiser-Portland currently has a CPPP (section 1833) Medicare contract under which 15,000 Medicare beneficiaries receive Part B services.

Kaiser's demonstration project with HCFA, which began in June 1980, has an enrollment of approximately 6,000 beneficiaries (4,500 new enrollees) in a comprehensive Medicare plan (M-plan), which provides the entire Medicare benefit package as well as some benefits not covered or only partially covered under Medicare. Eligibility is limited to Medicare beneficiaries who have A and B coverage, qualify for Medicare aged or disabled coverage, and who reside in the health plan service area. Enrollment is not offered to Medicare members who are institutionalized or who qualified for ESRD at the time of application, or to Medicare members who have Part B coverage only.

The M-Plan offers Medicare A and B covered benefits without deductible or coinsurance limitations, routine physical examinations, examination for eyeglasses and most immunizations, full coverage for prescribed home health care and outpatient mental health services (non-psychiatric). Under the demonstration, Medicare pays 95 percent of the AAPCC for the Portland metropolitan area and the Kaiser rate of profit, as reflected in the Adjusted Community Rate, is limited to that for private enrollees. The difference between 95 percent of the AAPCC and the ACR, called savings, will be returned to the Medicare beneficiaries as a reduction in dues and/or as new services. Kaiser is employing a variety of marketing approaches, including the use of spot TV advertising, to attempt to identify enrollment incentives which are most effective.

Medicare enrollment as of March 1981: 7737

INTERSTUDY -- Minneapolis/St. Paul, Minnesota

Plans: HMO Minnesota, SHARE Health Plan, Nicollet/Eitel Plan, and Med Center Health Plan

INTERSTUDY is acting as a broker for four HMOs that will test a competitive market model for Medicare beneficiaries in the seven counties comprising the Minneapolis/St. Paul area. Interstudy estimates that about 75 percent of the practicing physicians in the metropolitan area are affiliated with at least one health plan. The four participating plans currently have total enrollment in 1979 of approximately 136,000, about a 9 percent share of the marketplace. The four plans are: HMO Minnesota; Nicollet/Eitel Health Plan; Share Health Plan; and MedCenter Health Care.

Under the demonstration, the plans will offer various benefit packages to the more than 200,000 Medicare beneficiaries in the area. Each one will offer a low option plan consisting of all Medicare Part A and B services, plus at least one additional service or an expanded Medicare benefit. In addition, a high option plan will be offered, with additional benefits. The beneficiaries will be introduced to the various plans through Interstudy's "Wise Buyer" program which is a public education effort aimed at heightening beneficiary awareness of the various plans prior to an open enrollment period. The first open enrollment period will occur in May of 1981.

The capitation rate, which will cover both aged and disabled beneficiaries, will be equal to 95 percent of the Adjusted Average Per Capita Cost (AAPCC). The AAPCC estimates what the HMO enrollees would have cost the Medicare program had they received services in the fee-for-service sector. A key hypothesis of the demonstration is that competition among the plans for Medicare enrollees will cause each to offer as many additional benefits as is financially possible. Renal beneficiaries will not be eligible for enrollment; however, those who become renal patients after enrollment will be covered.

STATEMENT OF PAUL M. ELLWOOD, JR., M.D., PRESIDENT,

INTERSTUDY, MINNEAPOLIS, MINN.

I am Dr. Paul Ellwood, President of InterStudy, a nonprofit health delivery research and policy analysis group in Minneapolis. Eleven years ago, I first proposed a per-capita reimbursement approach to Medicare. InterStudy has been following the development of competitive medical plans since that time. At present, we are coordinating the Medicare capitation demonstration project in the Twin Cities. The Twin Cities is the only demonstration site involving multiple competing plans; four HMOs being offered to Medicare enrollees on a fixed capitation basis.

Congress is now debating changes in the Medicare program based on the installation of consumer choices and prospective per-capita reimbursement of providers. A new Medicare program would provide greater protection for senior citizens while rewarding them (through better benefits and/or lower costs) for choosing more efficient sources of care. Such a program promises significant gains for Medicare beneficiaries. The success of the new system, however, depends on making competitive medical plans widely available to beneficiaries. A new Medicare system will also afford us the opportunity to address a future problem -- the long-term care system -- at an early stage.

1. Applying market forces to Medicare will result in improved benefits and lower costs for Medicare beneficiaries. Providers and insurers who are competing to attract enrollees will have incentives to pass savings back to enrollees in the form of increased benefits and/or reductions in the costly copayments and deductibles Medicare recipients now face. Gaps in coverage, and the confusion that currently plagues Medicare as to what and how much is covered, will be alleviated. Competing plans will also be attractive to seniors if they can eliminate the need for seniors to file claims for reimbursement. The current Medicare demonstration

project in the Twin Cities is testing these hypotheses. We are finding that not only will prepaid plans compete along these dimensions, non-prepaid plans, and plans which do not have capitation contracts with Social Security, will try to offer similar advantages to their Medicare patients in order to keep them.

Predictions that a competitive system will function in this way rest on the assumption that savings can be generated to be passed back to consumers. Studies conducted by InterStudy and others indicate that efficient, high-quality health providers, whether prepaid or fee-for-service, should be able to deliver care to Medicare patients at a rate of hospitalization 20-50% less than the current average Medicare levels. The following table illustrates such reductions.

Table 1

Hospital Utilization Rates for Over 65
(adjusted data unavailable)

	Hospital Days/1000
United States (1976)	4163.7
Mayo, Olmsted County (1976)	2565.8
Marshfield Demonstration (10/80 - 5/81)	2882.5
Kaiser Portland Demonstration (1981)	1700.0
Fallon Demonstration (1981)	2700.0

Under competitive conditions, organizations will pass these savings on to Medicare beneficiaries in the form of lower premiums or added benefits. In cases where competitive medical plans are able to retain profits, their experiences will encourage more competition and lead to more choices for people on Medicare.

The Kaiser-Portland demonstration project illustrates how attractive benefits can be made if savings are passed back to Medicare enrollees:

Kaiser-Portland Demonstration

	Benefits	Charge
1)	A. Medicare benefits and B. comprehensive supplemental coverage	no charge
2)	A, B, prescription drugs, eyeglasses, ... and hearing aids	$6.00 a month
3)	A, B, and total dental care	$9.81 a month
4)	A, B, prescription drugs, eyeglasses, ... hearing aids, and total dental care	$15.81 a month

2. More and a wider variety of competitive plans will need to form if they are to be widely available to Medicare recipients. In the past, the government has focused on defining, promoting, and regulating HMOs as a model delivery system; it has not actively encouraged either insurers or providers to create a broader variety of competitive plans. One way to begin to do so would be to broaden the definition of what constitutes a competitive plan for the purpose of contracting with Medicare, as Senator Heinz has done. I would urge that the re-definition go even further. Removing the reinsurance provisions from the Heinz definition would effectively allow an even wider variety of organizational forms. A further section could be added to the definition which explicitly allows insurers to participate by paying them on a per-capita basis for those people to whom they already provide health insurance.

The way CMPs are reimbursed will clearly affect the speed with which they spread. The use of an "adjusted community rate" to control excess profits achieved by CMPs is clearly a deterrent to the formation of new types which might be very effective competitors. In my view, this mechanism represents a continuation of the very cost reimbursement philosophy that has made Medicare into such a fueling agent for medical care inflation, and such an instrument for the preservation of the status quo. If Medicare reimbursement rates are indexed for both health status and general inflation, the opportunity for plans to earn profits can only come through greater efficiency. An adjusted community rate then becomes an unnecessary safeguard.

Most health care providers and insurers have had little experience with risk arrangements for providing care to Medicare recipients. An inducement for them to enter into such arrangements might be to make cost-based reimbursement available during a predetermined start-up phase, with a bonus for those whose costs are below the indexed capitation rate.

3. The long-term care system poses potentially huge problems in the future as the population ages. Incentives for efficiency in Medicare will prompt plans to confront this problem now. Long-term care is more rigidly tied to government entitlement programs than acute care; it is already the greatest drain on state Medicaid budgets. Minnesota is cited as an example.

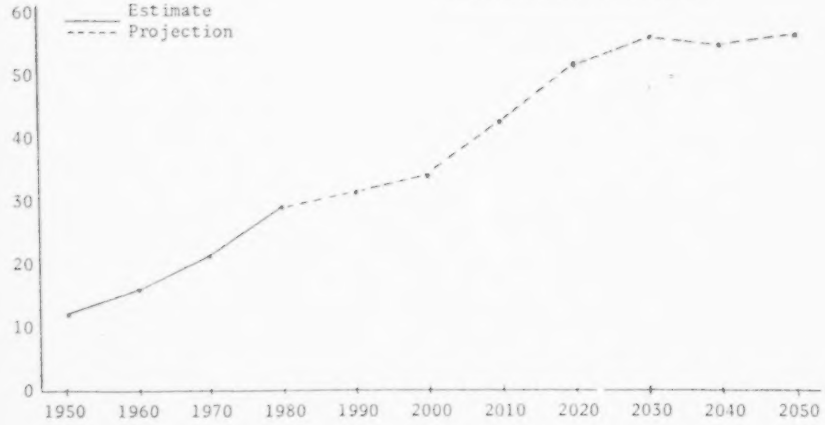
Table 2

Medicaid Long-Term Care Services

	Year	% of Medicaid Spent on Long-Term	Amount
Federal Government	FY78	41.9%	$7,583 million
State of Minnesota	FY80	71.0%	$ 402 million

The problems posed by the long-term care system can only be heightened as the proportion of older Americans rises in coming years. The number of people over 65 will approximately double by the year 2030.

Table 3: Number of Elderly in the United States: 1950-2050



Source: United States Bureau of Census

As the population ages, so will our need to find improved, efficient ways of caring for them increase.

Competitive plans under the current Medicare/capitation demonstration projects are attempting to expeditiously move patients out of the hospital and into less costly settings. In so doing, they have discovered the absence of effective long-term care programs which emphasize independence and life outside of institutions. Some innovations are already emerging from these demonstrations (which are necessarily limited precisely because they are just demonstrations), we can at least anticipate substantial improvements at the interface between long-term and acute care. A head start on this problem is essential since it has the potential to become even more serious economically than the one now facing the country with acute medical care.

STATEMENT OF SAMUEL L. HAVENS, PRESIDENT, PRUCARE, AND VICE PRESIDENT, GROUP INSURANCE, PRUDENTIAL INSURANCE COMPANY OF AMERICA

This statement is submitted on behalf of The Prudential Insurance Company of America by Samuel H. Havens, Vice President, Group Insurance and President of PruCare, Prudential's HMO subsidiary.

Prudential supports S. 1509, the Competitive Health and Medical Plan Act of 1981 (CHAMP), and we appreciate the opportunity to offer our observations and suggestions for this legislation.

At the outset I would like to summarize Prudential's involvement with HMOs so that the perspective from which we have developed our comments can be better understood.

Prudential's first direct involvement in HMO development was with the Harvard Community Health Plan starting in the late 1960s. Prudential representatives served as individual consultants to the plan in its early stages of planning and worked with the plan after it was launched.

Prudential's HMO management experience dates from 1973 when Prudential entered into a management contract with the Rhode Island Group Health Association (RIGHA), and agreed to lend it, at an appropriate interest rate, up to $1.5 million. At that time RIGHA was experiencing severe financial difficulty, and its ability to continue operations was in question. Prudential employees managed the plan through May 1980. By that time, the plan had become sound financially and was able to operate without assistance from Prudential employees. The Prudential loan is currently being repaid on schedule, and we are confident that the plan will continue to be successful.

Prudential has had experience with two additional HMOs which had been started prior to our involvement. The first was the Central Essex Health Plan, a prepaid group practice plan located in Orange, New Jersey. After this plan had operated unsuccessfully for a period of time and was rapidly drawing down its federal loan commitment, Prudential was asked by the Department of DHEW to consider taking over its management. Although we doubted our ability to make the plan viable, we agreed to assume management responsibility only because it was near our Corporate headquarters. No Prudential funds were invested in this HMO. After about one year of effort, which expanded enrollment and reduced expenses, it became clear that the plan would never be viable. The plan was closed down, with DHEW approval, when it still had $800,000 of ourstanding federal loans available. As far as we can determine, no plan member went without continuity of health benefits. There was no adverse employer or consumer reaction.

We were also invited by DHEW in 1975 to assume management responsibility for the Southshore Health Plan, an Individual Practice Association model HMO in Atlantic City. This plan had received federal planning and development grants, but was then denied qualification and operating loans. As a result, it had not commenced operations. We accepted the management responsibility without investing funds in the plan other than entering into a deferred arrangement for reimbursement of some of our expenses. The restructured plan was then granted qualification by DHEW. The plan has now reached an enrollment of 12,000 and is likely to continue to be viable. Prudential is still managing the plan.

The first Prudential-developed HMO started in Houston, Texas, in 1975. This plan uses the medical facilities of the MacGregor Medical Associates, a group practice which has been in operation for a number of years. This was the country's first federally qualified HMO which involved no federal grants or loans. The plan is financed entirely through Prudential capital and loans. The plan has more than met our expectations. The operations for 1979 produced net positive earnings one year prior to our original projections. Current enrollment is over 60,000, and we are optimistic that the plan will continue to grow rapidly.

In June 1979, we started an HMO in Dallas jointly with the Kaiser Permanente Medical Care Program. The Kaiser/Prudential Health Plan, which is jointly financed by the two organizations, is growing according to original plans and has financial results in accordnace with our expectations. Enrollment currently exceeds 20,000 persons.

Since 1980 PruCare has started new HMOs in Austin, Texas; Nashville, Tennessee; Atlanta, Georgia; and Oklahoma City, Oklahoma. Recently, in June 1981, PruCare acquired NorthCare, a Chicago, Illinois, HMO with 30,000 members. Over 100,000 persons now belong to PruCare HMOs in these various locations.

Twenty-four percent of eligible Prudential employees have also elected to receive their health care from one of the more than 45 HMOs made available

to company employees nationally. Our current role as owner, developer, manager, investor and customer demonstrates our commitment to HMOs.

Prudential has chosen to become active in this field for several reasons:

1. In addition to being providers of health care, HMOs provide economic security against the cost of illness. The provision of economic security to our customers is Prudential's fundamental purpose as an institution.
2. HMOs are a socially responsive and cost-effective method of providing health care. We believe they are in the best interest of the American public, the economy, and the health care system as a whole.
3. We believe that HMOs, when properly conceived and managed, can provide high quality and accessible health care in a competitive manner, while at the same time providing an adequate return on our investment.

Well managed HMOs have demonstrated their ability to contain costs and provide high quality health service to members. HMOs hold great promise for meeting the needs and solving some of the problems of our nation's health care system. It is most appropriate, therefore, that the Congress should consider arrangements which will make the benefits of HMO membership more widely available to older Americans.

HMO membership can be a valuable benefit to older Americans. Members receive coordinated care through an organized health care delivery system. The elderly would enjoy the benefits of physician guidance through the often confusing array of specialists and other services available for their care.

Access by the elderly to HMO membership has been frustrated, however, by the disadvantages of current Medicare reimbursement arrangements. For example, under currently available cost or risk-based arrangements final payment by Medicare to an HMO is made retrospectively and could remain undetermined and unpaid two or three years after services are provided. HMOs are also required to offer a Medicare benefit package that covers only Medicare-eligible services. This excludes preventive and health maintenance services and is alien to the concept of HMOs.

We believe that the adoption of an equitable system of prospective reimbursement can greatly expand the availability of comprehensive prepaid health care to Medicare recipients. For this reason we commend Senator Heinz and the cosponsors of S. 1509 for their recognition of the potential of HMOs and the realities faced by these organizations. If enacted, S. 1509 would be a significant step by the federal government to recognize competitive, cost effective health care delivery systems.

We endorse the basic framework of S. 1509, and we believe that with a few modifications the measure will create a workable mechanism to increase the availability of HMO membership to Medicare beneficiaries.

We believe S. 1509 would benefit greatly from the following modifications:

- Enrollment in both Parts A and B of Medicare should be a prerequisite of HMO enrollment under the CHAMP Act. This will help simplify administration by the HMO and hold down the costs associated with multiple categories of membership.

- The feature of the current HMO reimbursement law allowing HMOs to elect to have Medicare process Part A claims should be retained by the CHAMP Act. This feature is particularly suited to HMOs without a significant Medicare enrollment because it allows for the gradual assumption of this function at a later date.

- The disenrollment provision of the CHAMP Act should be revised to provide for disenrollment only during the annual open enrollment period, upon relocation from the service area or upon termination of Medicare eligibility. This arrangement will provide some minimal protection to the HMO against adverse selection. Medicare members would thus be treated in the same fashion as non-Medicare HMO members.

- The CHAMP Act includes quality of care standards which will apply to participating Competitive Medical Plans. Federally qualified HMOs are already required to meet comprehensive quality of care standards under the federal HMO Act. Coordination between the agencies administering these two very similar sets of requirements should be mandated by law to avoid adding a layer of duplicative regulatory burdens.

Historically, HMO boards of directors have shown themselves to be responsive to the needs of HMO members. Board decisions on HMO policy and coverages are made with serious consideration of member interest. Federally qualified HMOs are required to have one-third of their board membership for HMOs made up of consumer members. We feel that these boards are capable of deciding how and when any savings experienced under the CHAMP Act should be applied to additional services, capital investment, premium rebates or retention of profits. The bill should not mandate how the difference between the Adjusted Community Rate and the Adjusted Average Per Capita Cost must be spent. Appointing a panel of Medicare members to make such decisions could also cause dissension among non-Medicare HMO members.

One key to the success of the CHAMP Act would be the ability of HMOs and the Secretary of HHS to agree on the Adjusted Community Rate for each plan. This process raises the prospect that HCFA will engage in determining allowable HMO expenses in much the same fashion as is currently the case with hospitals. The attractiveness of the CHAMP Act would be largely reduced if HCFA is to set HMO salaries or the acceptable costs of marketing to individual Medicare enrollees, depreciation schedules and chargeable interest rates.

The CHAMP Act makes provision for how funds should be used if the Adjusted Community Rate is less than the AAPCC. The Act should also make provision for the recoupment and amortization of losses by an HMO should the 95% of AAPCC prove inadequate. Health maintenance organizations can provide a cost effective, comprehensive health care alternative for Medicare beneficiaries. With the modifications we have suggested, this alternative can be made more available to elderly Americans with concurrent cost savings to the federal government.

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